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CALIFORNIA STATE JOURNAL OF MEDICINE

The Immutable Law of Progression

NATURE abhors stagnation and has established laws which render it impossible; we must make progress either forward or backward, and it is always more difficult to measure this progress in ourselves than in others. We are prone to criticize our neighbor or competitor as to his progress, but do we often apply the same cold scrutiny to ourselves? In nothing can we better gauge our progress than in critically studying something that we wrote last year or five years ago. Have we traveled away beyond it in straight thinking, in diction and in real knowledge, or are we somewhat startled, not to say alarmed, by the feeling that we are slipping—that we are incapable of keeping up the pace set by ourselves? It is good for us all to check up on our available mental assets from time to time. In this way only are we likely to forestall mental bankruptcy.—Robert Pollock, M.D., (Bulletin, San Diego County Medical Society.)

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ORIGINAL ARTICLES

RESPONSIBILITY FOR STATEMENTS AND CONCLUSIONS IN ORIGINAL ARTICLES

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ERYTHEMA INDURATUM*

(Report of a case treated with tuberculin and the Kromayer Lamp.)

By H. E. ALDERSON, M. D. and H. C. COE, M. D.
(From the skin clinic, Stanford University Medical School, San Francisco.)

This case of erythema induratum is reported because of the good results obtained in treatment with tuberculin and ultraviolet light.

The patient, an American schoolgirl, referred by P. H. Pierson, complained of ulcers on both legs of two months' duration. The lesions had first appeared as nodules in the skin, which were neither painful nor tender. These nodules gradually broke down, leaving indolent ulcers characteristic of the disease.

The family history disclosed the fact that the father had had similar ulcers on his legs thirty years ago. There was no history of syphilis or tuberculosis in the family. The patient had never been in contact with tuberculosis, as far as she knew. There was nothing in the patient's past history which could influence her present illness.

Physical examination showed a well-developed, very well nourished young woman 16 years of age. The pulse and temperature were normal. The thyroid gland was slightly enlarged, but there were no signs of toxicity. In the right anterior cervical region there was an enlarged lymph gland, about

1 cm. in diameter. It was firm and not adherent to surrounding structures. The tonsillar fossae were clean. Tonsillectomy had been thoroughly done nine years prior to examination. The heart and circulation were normal. There was some harshness to the breath sounds at both hilus regions; otherwise, the lungs were negative and the abdomen and extremities presented nothing abnormal excepting the leg ulcers.

The ulcers were situated on the lower third of both legs. There were four on the left leg (two on the anterior surface, one on the medial aspect, and another on the posterior surface). There was one ulcer on the anterior surface of the right leg. They were irregularly annular in shape, and about 4 cm. in diameter. The ulcers were fairly deep, the edges somewhat raised and crusted, but fairly clean-cut. The bases were covered with a sero-sanguineous exudate and some necrotic tissue. They were not tender nor acutely inflamed.

Laboratory examinations showed a normal blood count and a negative urine. The Wassermann test was negative in two laboratories. Smears were made from the edges of the ulcers and stained for tubercle bacilli, but none were found.

X-ray plates of the chest showed calcified glands at each hilus and a pleural scar across the apex. This, with the enlarged cervical gland pointed toward past tuberculosis.

The history and appearance of the lesions established the diagnosis of erythema induratum (Bazin). The patient was given a course of tuberculin injections as outlined below by P. H. Pierson, and we administered the Kromayer lamp treatment.

Tuberculin O. T. was given in increasing doses, the dosage being regulated according to local and focal reactions and the patient's temperature. The dosage varied from .001 mgms. to .02 mgms. The smaller doses were given three times a week and the larger ones twice a week.

The Kromayer lamp was applied twice a week without lens, the window of the lamp being held as closely as possible to the ulcer without actual contact. The exposure was for 15 seconds.

About two weeks after beginning treatment a focal reaction was noticed about the ulcers. They became larger and were surrounded by a zone of hyperemia. The patient said the lesions were painful and they were tender to touch. A month later the edges of the ulcers were clean and smooth, healthy granulations covered the bases, and epithelium began to grow in from the edges. In four months the lesions were completely healed. The

* Read before Section on Dermatology at the State meeting, at San Francisco, June 22, 1923.



patient was last seen a few days before reading this paper, four months after the ulcers healed. She has no new lesions and the smooth purplish scars, the remains of the ulcers, are beginning to fade.

A survey of the literature shows that tuberculin has been successfully used by others in the treatment of erythema induratum. In 1909 Clark reported on the therapeutic value of tuberculin in this disease. Fordyce in 1911 reported improvement in a case thus treated, and MacKee in 1913 reported the cure of a case. The Kromayer lamp as a local application has also given therapeutic results. Recently, Oliver reports cures in five cases of non-ulcerated erythema induratum by the application of the lamp with pressure over the nodules for a one-minute exposure.

SUMMARY

Ulcers on the legs of a young woman were diagnosed as lesions of erythema induratum. The patient was treated with tuberculin and the lesions with ultraviolet light by the means of the Kromayer lamp. Lesions were completely healed in four months. They have remained healed and there have been no new lesions.

240 Stockton St.

DISCUSSION

Edward D. Lovejoy, Brockman Building, Los Angeles—The paper of Alderson and Coe is a valuable contribution, in that they have added to our knowledge of treatment and results of treatment. It is only by collecting such data that we can come to a just evaluation of the methods at our command in the care of dermatological diseases. Far too many

reports are wasted because we do not consider a single case or small group of cases of sufficient value to publish, but in the present instance this report added to the previous ones by Clark, Fordyce, Mackee, and Oliver makes an increasing collection from which valuable facts may be later deducted.

Erythema induratum has always been difficult to bring to an ultimate cure, relapses being of frequent occurrence even with the use of tuberculin combined with the local dressings and cleansing of the ulcers which we have previously employed, but the report of Alderson and Coe makes us hopeful that the combination of treatment here employed may serve to destroy the cause and prevent recurrence.

In regard to the case itself, the author leaves us a little in doubt as to whether he considers the focal reaction due to the tuberculin injection or the Kromayer lamp, and also if any change was made in the treatment or frequency of the treatment following the appearance of the reaction.

John C. Yates, Watts Building, San Diego—I wish to acknowledge, in the discussion of paper by Alderson and Coe, of a case of erythema induratum. It is rather difficult to know where to start, as they give us very little to start upon. I appreciate very much the report of one case, as it brings us into more intimate contact with the patient than where the statistics are given of one hundred cases, or perhaps more. I have never been satisfied from my contact with the various writers on this subject, that all are agreed as to its being a tubercular condition, primarily; that is, the patient is usually one having poor circulation in extremities, and the condition existing is a phlebitis, with choking of lumen of vessels by leucocytes, and tuberculosis bacilli are seldom found, although patient usually is suffering with, or has healed lesion of tuberculosis, probably from the predisposing cause, therefore giving one several possible foci of tuberculosis infection.

The laboratory findings in this case showed nothing in particular, outside of some probably healed lesions in apices; however, we will take Alderson's and Coe's diagnosis for granted.

This brings us to treatment administered, which consists of two parts—that of tuberculin internally, and light externally, the description of which is rather vague, in that the authors state the dosage was "regulated according to local and focal reaction, and the patient's temperature," and then apparently "the smaller doses were given, three times a week, and larger ones twice a week."

The treatment of erythema induratum has been conducted for several years by use of tuberculin, together with the usual care of tubercular patients, with more or less fair results; also it must be noted many of these cases tend to spontaneous recovery, at least for the time being; therefore, it comes to the consideration in the treatment of this case of the use of the violet ray as an adjunct, administered through use of the Kromayer lamp, exposure, without lens, for fifteen seconds twice weekly. The author speaks of a focal reaction occurring after two weeks, but does not specify any difference as to this reaction and what might have been from his focal reaction of tuberculin, and although you might get a reaction from Kromayer in ulcerations of any character, and by hyperemia disseminate the leucocytes, I do not feel that the exposures were of long enough duration to do this in an encrusted ulcer with a serosanguineous exudate of any amount, which must have occurred with necrotic tissue. The only question that now remains, can erythema induratum be cleared with ultra violet rays alone, or must we use tuberculin in conjunction?

Philip H. Pierson, 516 Sutter Street, San Francisco—A question was raised in regard to whether this was definitely tuberculous disease and to what has been said in regard to the existing cervical gland, scars at both hiluses and across the apices, the rather destructive type of leg ulcers. I might

add that there was a definite focal reaction in the ulcers, more redness, pain and induration following the injection of one mgr. tuberculin used for diagnostic purposes before the treatment was started.

The question has also been raised as to whether the ultra violet lamp alone would suffice in treating such a tuberculous manifestation, and to this I would say, probably not. And my reason for saying so is that you cannot treat a generalized infection with perhaps only a few superficial manifestations by local treatment only. General regulation of life, habits, diet, rest, etc., is extremely important. Also the effect of the tuberculin on the specific resistance is a great factor in preventing recurrences. I do not deprecate in the least the added help of the lamp in hastening the effect of tuberculin and general hygiene, but I feel that all should be carried out rigidly if we are to be successful both for the present and the future.

Dr. Alderson (closing)—In reply to Lovejoy's discussion we can state that months have elapsed, and the patient who has been reporting at intervals remains perfectly well. She has become a professional dancer, and is quite successful in her work. We expect to keep her under observation for several years before pronouncing her permanently cured. The focal reaction referred to was due to the tuberculin injection which phenomenon offers additional diagnostic evidence asked for by Yates. The tuberculin injections at this stage were temporarily interrupted, but the Kromayer lamp treatments were continued. Pierson has already discussed his part of the treatment. Yates' remarks regarding the sufficiency of the ultraviolet-ray exposure would be justified if the ulcers at the time of treatment were covered with crusts, but the treated surfaces were cleaned, leaving an unobstructed field for the light rays. It is now generally accepted that erythema induratum is due to the tubercle bacillus. In our opinion, a favorable result would have been observed in time from the ultraviolet light alone, but combination with the tuberculin injections brought about involution of the lesions in much less time than otherwise would have been the case.

Harry C. Coe (closing)—I believe that the questions asked by both Lovejoy and Yates have been answered by Pierson and Alderson. I might add that in the paper we referred to E. L. Oliver's recent report of cure by the use of Kromayer lamp alone in case of erythema induratum. This would answer Yates' question on that point.

Professional Pirates—Under this heading, the Financial Times, San Francisco, October 13, 1923, publishes the following editorial: "Next Wednesday (providing there is no golf match on) the State Board of Medical Examiners will summon thirteen physicians to appear and show cause why they should not be deprived of their right to practice medicine in California. Mind you, thirteen in our own State—twelve charged with performing illegal operations, and one for violation of the poison act. Very Pretty! In the mind of the editor, the three greatest professions in the world are law, the church, and medicine. A chief justice should advocate and protect the citizens with law and order. The ecclesiastic is given the rare privilege of teaching the doctrines of Christ and cementing love and tolerance. The physician, honored by degrees, should respect the humanitarian and skillful knowledge he possesses. Bringing children into the world and nursing and treating both young and old alike, when in ill health, are all a part of his duties. These three professions should be a firm foundation for all times. Should be! Now, what do we discover? The foundation is cracked and is leaky. Worms of distrust and selfish gain are eating into the concrete pillars. No penalty is too severe for this ilk. Those noble medicos, who will undoubtedly suffer through this blight brought on their profession by their so-called colleagues, should be vindicated swiftly and surely for all times.

THE TREATMENT OF ACUTE OSTEOMYELITIS*

By A. J. OCHSNER, M. D., Chicago

In discussing this subject it is of the greatest importance to direct attention to the fact that harm comes to patients suffering from acute osteomyelitis as a rule, because of the fact that the diagnosis is not made until great destruction has been done from advancement of the disease, which could have been prevented with the greatest ease had an early diagnosis been made, and to point out the reasons why the diagnosis is not made early, and to supply the remedy for this error.

In order to clearly understand the history and progress of the disease one must bear in mind the structures involved in this infection, which enters the bone through the nutrient artery and progresses through the peculiar circulatory system present in the bone. Taking as an example one of the long bones, we have in the center the medullary cavity, which is especially rich in blood vessels through which the infection can progress readily if no outlet is provided to the external surface of the extremity involved. From this cavity the vessels extend into the hard portion of the bone through the Haversian canals, which communicate in turn through the tiny canaliculi with the lacunae, and ultimately with the periosteum. The latter structure is thick and hard and difficult to perforate, consequently the infection is confined within this dense covering and backs up into adjoining portions of the marrow until ultimately the entire shaft may be involved.

On the other hand, if an exit is provided by an incision down to the bone through the periosteum, the lymph stream immediately begins to carry the infectious material away from the original location. The pressure is relieved at once, and the pain subsides immediately and the infection ceases to progress, so that there is no danger of further involvement of bone which had previously remained free from infection.

Occasionally, the primary point of infection is located immediately underneath the periosteum; especially is this true in cases in which there has been a contusion of the periosteum. In these cases an incision through the periosteum down to the bone will result in complete, permanent relief without any involvement of the bone proper. On the other hand, if this treatment is not instituted early the infection may destroy a portion of the bone before relief comes from perforation of the periosteum by pressure necroses and evacuation of the pus through an abscess in the soft tissues overlying the periosteum.

In reviewing the histories of the cases which have come under my personal observation, I have found that an early diagnosis has been made only in those cases in which a careful physical examination had been made. The delayed diagnoses were due to the fact that the trouble was looked upon by the parents, or the family physician, or both, as a case of rheumatism or growing pains, the diagnosis having been based entirely upon the fact that

* Read at the Utah Medical Association's annual meeting, Salt Lake, June, 1923.

the child complained severely from pain in one of the extremities.

A careful review of the case invariably brought out the fact that the child had suffered previously from some localized form of infection. In many cases this was present in the form of tonsillitis, fernuculosis, otitis media, sinus infection, infected dental roots, acne or some form of intestinal infection. The bacteria present varied, staphylococcus being the most common, but pneumococcus, streptococcus, colon bacillus, Klebs Loeffler bacillus and typhoid bacillus and others were present in some of the cases.

In many of the cases that come later for treatment, there are two or more varieties of micro-organisms present. The cases which came under our observation early with a diagnosis had all been examined physically with great care by the family physician, with the result that it was possible to prevent the spread of the infection and that the cases recovered with the destruction of only a small amount of bone or none at all. The attack may be mild if the infection is not virulent amounting to slight pain usually near the end of one of the long bones, but occurring at times in any bone of the entire skeleton.

In other cases the attack may be extremely violent so that the patient may suffer extreme pain within a few hours after the beginning of the attack. The temperature may rise rapidly to exceed 103 degrees F., and there may be a high leucocyte count, although it is dangerous and foolish to postpone operation in any case because of a low leucocyte count.

The symptom, however, which is of supreme importance, is the pain upon pressure over the portion of the bone involved. It is difficult to overlook an acute osteomyelitis, if one carefully goes over the bone with pressure. The area which is painful upon pressure may be absolutely circumscribed in very early cases, while later on it will extend over a larger area and may extend over the entire bone, but whenever pain is present upon pressure immediate surgical interference is indicated, and the less time is wasted the better.

One form of preliminary examination should be condemned in the most vigorous terms in cases in which a diagnosis of acute osteomyelitis has been made upon physical examination. I refer to the X-ray examination. Many cases are not operated early because an X-ray examination fails to show an abnormal condition. In these cases usually repeated X-ray examinations are made until one shows the presence of a sequestrum or until external swelling indicates the presence of the underlying infection. By that time the amount of destruction is much greater than it was when the patient was first examined, and when by the simple physical examination a positive diagnosis could have been made. Unfortunately, the fact that the X-ray is most valuable in determining the extent of necrosis in cases of chronic osteomyelitis has given the impression that it is also valuable in acute cases, and has caused this foolish practice to be employed to the great harm of many patients. It should never be employed in any case in which drainage has not already been provided by the split-

ting of the periosteum over the entire area over which the bone is tender upon pressure and at least 2 or 3 cm. beyond, above and below.

This is the treatment that should be instituted at once upon making a diagnosis of acute osteomyelitis, and the diagnosis should be made at once upon finding tenderness over the bone upon pressure, and every case should at once be examined by making pressure upon the bone from end to end as soon as a patient complains of pain in one of the extremities.

Under no condition should time be wasted in obtaining X-ray plates, and if for any reason an X-ray plate is made because it is demanded by the family or by some stupid consultant, a negative result should never prevent an immediate operation, which should never go beyond splitting all the overlying tissues through the periosteum down to the bone. The incision should always be very free, so that there can be free escape of lymph which will carry with it the infectious material. This can be materially increased by the application of a large dressing saturated with a saturated solution of boric acid in hot water covered with oiled silk or some other impermeable dressing. Additional solution should be added every three to twelve hours. Within half an hour after the application of these dressings of saturated solution of boric acid, the boric acid can be demonstrated in the patient's urine. Whether this fact is of any importance in the treatment has not been definitely proven, but it is an interesting fact.

As a rule, the operation for acute osteomyelitis should go no further than the free splitting of the periosteum because this will stop the progress of the disease, and many times a portion of bone which appears to be in a hopeless condition will recover entirely or in part if left in place. Moreover, these patients are often extremely ill at the time of operation, and many deaths have occurred from the shock caused by an extensive operation which could have been avoided had the patient not been exposed to the unnecessary trauma.

Moreover, even in cases in which a large portion of a bone is in a hopeless condition at the primary operation, if left in place it will serve as a splint for the development of an involucrum, which will in turn replace the bone and leave the extremity in a very much better condition than it would be if the dead bone had been removed at the original operation. Occasionally, but very rarely, an exception may be made in a case in which there is only a very small circumscribed point of severe tenderness. In such a case there may be a small circumscribed abscess surrounding an infarct, which may have been discovered very early. In these rare cases one may properly use a very sharp gauge after incising and reflecting the periosteum and then, without traumatizing the bone, one may cut out the overlying bone and carefully evacuate the small abscess with a sharp curette. The number of cases in which this form of treatment is indicated is, however, extremely small.

After the patient has recovered from the operation for acute osteomyelitis, one should invariably try to determine the primary location of the infec-

tion. We have met many cases in which recurrent osteomyelitis was apparently due to the fact that the patient had infected tonsils, which had been overlooked, or infected roots of teeth or sinus infection, but most commonly the infection seemed to be located in the tonsils; sometimes these were small and buried, but contained abscesses which could not be demonstrated until the tonsils were removed. For a number of years we have made it a routine practice to remove the tonsils in all cases of acute or chronic osteomyelitis. Many of these cases suffer from chronic ferunculosis or chronic acne.

Among these cases who suffer from ferunculosis there are many who eat great quantities of sugar, which seems to predispose to the formation of superficial infection which in turn may supply the infectious material which is carried by the circulation into the bones causing osteomyelitis. These patients should give up the use of sugar in every form.

CONCLUSIONS

My experience, which covers a series of more than 200 histories, 151 of which I have analyzed, will justify the following conclusions:

1. In every patient suffering from pain in any bone, the latter should be carefully palpated at once.
2. Pain upon pressure over a bone indicates the presence of osteomyelitis or periostitis.
3. The earlier this is demonstrated the less destruction will occur if operated immediately.
4. The operation should consist in splitting the overlying tissues down to the bone through the periosteum.
5. The incision should extend beyond the painful area above and below.
6. The periosteum should be loosened to 1 or 2 cm. on each side of the incision.
7. As a rule, this should be the extent of the primary operation.
8. In rare cases of very circumscribed infection, the infectious area may be very carefully excised, care being taken not to spread the infection by rough handling of gauge, which should be very sharp.
9. Hot, moist dressings with electric light treatment hastens recovery.
10. The shaft of long bones should never be removed until involucrum has been formed.
11. The primary focus of infection should always be determined if possible.
12. As soon as the patient has recovered from the acute operation, the primary focus of infection should be removed if possible.

2106 Sedgwick Street.

Classified by the Newspapers—The following advertisement appeared in the classified section of some of the daily papers recently:

For Rent—Something New. Just what you have been looking for. Studio offices complete, with apt. conveniences. . . . They are suitable for chiropractor, musical, dramatic or academic instructor, osteopaths, hairdresser or similar professional lines.

A CASE OF SIMULATED PREGNANCY AND DELIVERY

By A. D. ELLSWORTH, Fresno

Cases are not rare in which a woman, for any one of a variety of motives or for none at all, deceives herself or attempts to deceive others in the belief that she is pregnant. It is much more unusual to meet with cases in which the pretense is made that delivery has taken place.

The motive in such cases is usually apparent, such as to obtain damages, to compel marriage, or to gain admission to a charitable institution and, as a rule, the claim is made that delivery was more or less remote, or at least not very recent. There seem to be no cases reported in which the affair has been staged in quite as elaborate a manner as in the present case, which is all the more surprising when we consider that the chief actress in the drama was an ignorant Mexican woman who had never had children.

A word of explanation as to her motive. It is almost unheard of for a Mexican woman of this type to seek or to produce an abortion; their desire is to have large families of children, who are to them a sort of insurance against want in old age. Women who have had as many as seven children will come to the doctor to find out what is the trouble that they do not have more. When a woman of this class is married, if she does not soon begin to produce this form of insurance, there is very apt to be trouble in the family.

In this case the young woman, after being married a few months, had evidently announced that she was pregnant. Later, when she found she was mistaken, she sought for some means by which she could find the "easiest way out."

The history given, which was, of course, partly fictitious, was as follows:

M. F., age 25, had never had any children. She had been married eleven months. Her last period had been in April or May (she was not sure which), which would make her at this time five or six months pregnant. She said that the day before she had been standing on a box reaching for something on a shelf, when she fell, striking the floor in a sitting position. This was at 4 o'clock in the afternoon, and nothing further had happened until 3 o'clock the next morning, at which time she said she had had a severe, prolonged pain and had passed a mass of tissue, which was shown me for examination.

In the poor light which was available, this might easily have been mistaken for an afterbirth. One feature, however, demanded inquiry, and that was how there could be so well developed an umbilical cord, but no foetus. She had not been to an old-fashioned toilet, and there seemed no other way of accounting for the absence of the foetus.

Although it is better, I believe, not to make any vaginal examination in such cases, at least in the midst of such unsanitary surroundings, yet here was a case in which it seemed to be imperative. Accordingly, a vaginal examination was made with a sterile glove. There was no softening or relaxation of the perineum, the cervix was hard and undilated, and the fundus was in the normal non-pregnant position.

The mass of tissue was taken away for further examination, and, in order that there might be no question, was sectioned and examined under the microscope.

Here is what this ignorant Mexican woman had done. She had taken a pig's liver, and on the undersurface of this she had punched a couple of holes. Through these she had passed a piece of pig's intestine, one end of which was then split; through the opening thus made she had passed the other end of the piece of intestine, and the loop thus formed had been drawn up tight, so that this "cord," which was about eight inches in length, appeared to come directly from the liver substance without any knot being apparent. Along with this work of art she had included a couple of collapsed lungs, evidently also from the pig, which served in the role of blood-clots.

As there seemed nothing to gain by undeceiving her family, they are still under the impression that a most unfortunate miscarriage has taken place.

Rowell Bldg.

A FEW NOTES ON HALLE'S CLINIC, WITH ESPECIAL REFERENCE TO HIS ENDONASAL SURGERY*

By ROBERT D. COHN, M. D., San Francisco

On my leaving Berlin this summer, after having spent a couple of months at Halle's clinic, it appeared to me a matter of regret that Halle's varied and important contributions to rhino-laryngology, especially operative, during the past ten to fifteen years had thus far not appeared in book-form and were accessible only in scattered journal articles and society reports, as well as to some extent in recent text-books. Halle stated that such a book is in preparation, but that owing to conditions in Germany its publication in the immediate future seemed far from assured. He had the kindness to place at my disposal his numerous reprints. These and my own observations and jottings are the basis of these notes.

Turbinectomy—Halle does no turbinectomies. Conchotomies and turbinectomy scissors are under the ban in his clinic. With its menace of subsequent rhinitis atrophica and pharyngitis sicca, he considers turbinectomy "unphysiological mutilation." He cuts off hypertrophied tips, but never sacrifices the structure proper. In operating in the upper and posterior parts of the nasal chamber he does not amputate the middle turbinate, but secures through its temporary subluxation the necessary space in which to operate.

Submucous Septum Resection—This is the most frequent of all the operations done. There is first of all the usual indication of impaired nasal respiration *per se*. In addition to that, Halle, as early as 1900 (*Zur Behandlung des Empyems der Highmoreschnecke*, Berl. Klin. Woch. 1900, No. 35), advanced the theory that normal nasal respiration is the main essential for the cure of acute and chronic empyemas, especially of the antrum and sphenoid, respiratory air being necessary for the mucous membranes not only of the nose itself, but

likewise of the sinuses. He believes that the normal respiratory air current, both inspiratory and expiratory, by negative pressure draws the sinus fluids from the sinuses; that this air moreover is antiseptic and, acting by suction, tends to dry out the cavities. Hence, many empyemas, especially antral, are cured spontaneously as soon as normal nasal respiratory conditions are restored. As, furthermore, almost all intranasal operations performed require a maximum of operative space, a septum correction almost invariably precedes the various operative procedures described below.

The septum correction in adults is always done under local anesthesia and its technique except in one point is that practiced by American rhinologists. The incision is a slight modification of that of Killian. The cartilage is removed with a straight Ballenger swivel knife, is then pared down somewhat and thereupon reimplanted, the septum flap being sutured with Halle's own crook-shaped needle. Infection and septum abscess are not feared.

As to the operation in children, Halle believes that it should be done only exceptionally before the twelfth year. However, he has frequently operated upon children of 8 and some as young as 4. In the last-named cases the operation was under general anesthesia; in children from 8 upward he operates, as a rule, under local anesthesia.

Operation for Closing of Septum Perforation—

This was first reported, with demonstration of cases, to the Berlin Laryngological Society in 1919 and published in the "*Monatsschrift fuer Ohrenheilkunde*" in 1921. Up to that time Halle had done the operation in 60 cases, with reported complete success in 56 and incomplete in 4. The operation is a modification of the Yankauer plastic and consists in the formation of two or three small flaps along the lower edge of the perforation, which are turned into it and partially close it. A large semi-circular flap is then outlined above the perforation and, after being displaced downward so as completely to cover the perforation and the smaller lower flaps, is carefully sutured in place. Tampons in the opposite side serve to press the smaller flaps against it until union ensues. The crescent-shaped defect resulting in the septum above heals promptly by epithelization. A good description of the operation is to be found in Passow and Claus's "*Operationen am Gehoergang, an den Tonsillen und in der Nase*," Leipzig, 1923.

The operation is easy in the reading and difficult in the performing. In the one case that I witnessed the operation was done on a man of 30 for a traumatic perforation, the result of an earlier septum correction. Although local anesthesia was perfect and the patient exceptionally tractable, the operation even in Halle's hands was difficult, tedious and troublesome.

Endonasal Frontal Sinus Operation—This is Halle's chef d'oeuvre, his main contribution to rhinological surgery. It is based upon the earlier operation of Fletcher Ingals, and was developed in the years just before 1910. Halle's technique is very briefly as follows: After the usual cocaine-novocaine anesthetization the middle turbinate is subluxated toward the septum. A large mucoperiosteal flap corresponding to the entire region in

* Read before the San Francisco County Medical Society, November 27, 1923.

front of the middle turbinate is then made by means of three incisions: the first from the head of the middle turbinate upward to the roof of the nose, the second extending thence along the roof of the nose to the piriform aperture, the third thence along the free edge of the aperture to the head of the inferior turbinate. The flap thus made is turned down over the inferior turbinate. The agger narium is now chiseled away, whereupon the anterior ethmoid cells and the opening into the frontal sinus come into view. With Halle's blunt-headed pear-shaped electric burrs this opening is now enlarged with ease and, above all, with safety. The frontal sinus is then curetted, the muco-periosteal flap thereupon replaced, and the nose packed. The usual simple post-operative treatment follows. A broad permanent communication between the frontal sinus and the nose results, normal natural drainage is restored, and ideal conditions are created for whatever subsequent irrigations and the like may be necessary.

Halle has never claimed that his intranasal method could or would supplant all external operations. As a matter of fact, in 1910, when he reported his first series of nineteen cases (Berl. Laryngol. Gesellschaft, November, 1910), he merely modestly hoped that in certain cases the external operation would thereby be rendered unnecessary and that within its limitations his procedure would not be without benefit. Since then his series has grown from 19 to over 850, and in the light of his experience in the past twelve years he now believes that in chronic frontal sinusitis no external operation whatever is at any time necessary in almost 95 per cent of all cases. He states that the Killian operation, which for over twenty years alone dominated the field and was the undisputed operation of choice, now no longer holds that position. Due to the uncertainty of its final results and the hazards of its outcome cosmetically, it shares, in common with all other similar external frontal sinus operations, ever-increasing disfavor.

Ethmoid Operation—Halle's present ethmoid technique, which he first reported in 1914, is as follows: The middle turbinate is subluxated and pressed tightly against the septum, whereby an unobstructed view of the middle meatus is obtained. With a long, narrow knife two sagittal incisions are made, one just under and along the lateral surface of the middle turbinate, the other along the medial surface of the lamina papyracea, both meeting at the head of the middle turbinate. The ethmoid cells within the area thus defined can now be removed with safety with punch forceps and curette, provided the operator remains within the lines of the two incisions, the middle turbinate acting as a safety-wall against injury to the cribiform plate.

This method suffices for the opening and exenteration of the middle and posterior ethmoid, not for the anterior, however. Halle exposes and obtains access to this latter, including the infundibular cells, by means of the muco-periosteal flap described above. He therefore, as a rule, clears out the anterior ethmoid cells in the course of his frontal sinus operation.

Sphenoid Operation—Halle refers to the relative

rarity of sphenoid disease. He states that in some years he does not see a single chronic sphenoid empyema and that up to 1922 he had operated only thirty-four cases. While he finds that in general a more or less extensive removal of the anterior wall suffices, in some cases of long standing with pronounced degeneration of the mucosa, the opening, however large, tends to close. In these cases he makes two flaps in the shape of an H, the lower flap as large as possible. After the anterior and a large part of the inferior wall have been removed (the latter by means of his pear-shaped burr) the two flaps are turned into the cavity, where they are kept in place with small tampons.

Radical Antrum Operation—In conformity with his principle of performing all nasal operations as far as possible intranasally, Halle confines himself almost entirely to the Canfield-Sturmann method. This method obviates the necessity of an oral incision with the possibility of a subsequent fistula, the post-operative reaction is minimal, the patient can eat and drink immediately after the operation, and after-treatment through the mouth is avoided.

Blindness Following Injections into Orbit—Halle warns insistently against all pre-operative injections into the orbit. After having reported two cases of his own in which, following such injections, immediate total blindness resulted, in March, 1923, he reported four further such tragic cases in the practice of others, but coming to his notice. He believes the condition due to an acute edema in the region of the optic foramen. Precisely such a case came under my observation while at Halle's clinic: In a young girl of 18, an injection of 2 or 3 ccm. of $\frac{1}{2}$ per cent novocaine had been made into the left cheek just below the lower orbital ridge preliminary to a left antral operation. By a mischance the needle probably entered the inferior orbital canal. A few moments later there followed extreme swelling of the lids and total amaurosis of the left eye with enlarged immobile pupil. Halle immediately made a number of broad and deep incisions into the orbit above and below, including a broad opening of the orbital periosteum. Great haste was necessary, he stated, as a few hours' delay would undoubtedly result in permanent blindness. On the removal of the bandage on the following morning the patient, to the relief of everyone, could count fingers, and in a few days the eye condition cleared up entirely.

Ozaena Operation—As is well known, it was Lautenschlaeger who first conceived the brilliant idea of curing ozaena by an operative narrowing of the abnormally patent nasal chambers. Whatever may be the ultimate fate of Lautenschlaeger's theories as to the etiology of ozaena, there can be no question as to the striking results of the operation he devised for this purpose. The aim of the operation is to bring the medial wall of the antrum, that is, the lateral wall of the nose, up against the septum and to keep it pressed in that position until more or less extensive union results between the turbinates and the septum.

Halle was quick to recognize both the great merits of the operation and the difficulties of its technique and promptly applied himself to the task of its simplification. Instead of the oral he chose,

as usual, the nasal route and by 1917 had perfected a method which, in its relative simplicity, is a decided advance upon the original Lautenschlaeger method. Halle's technique is briefly as follows: An L-shaped incision is made in the nasal mucosa beginning in front of the head of the middle turbinate and extending downward to the head of the inferior turbinate, thence continuing horizontally across the floor of the nose to the septum. Through this horizontal incision the mucoperiosteum lining the floor of the nose is elevated and the lower anterior portion of the nasal wall of the antrum brought into view. The entire lower border of this antral wall is now chiseled from the nasal floor, whereupon the anterior vertical border of the antral wall is chiseled through. The result is a broad opening from the nose into the antrum, which if diseased may now be readily curetted. Hereupon the entire inner (medial) antral wall is carefully pushed over to the septum, against which it is held tightly by gauze-packing in the antrum, the turbinates and septum having previously been refreshed in order to promote the formation of adhesions. These adhesions can easily be separated later in case a too pronounced narrowing of the nasal chambers follows the operation. Halle states that thus far he has not found this necessary.

In the four years from 1917 to 1921 Halle's operated cases totaled 131; of these he was able to follow up 76 longer than one year. His conclusions are: 1. Lautenschlaeger's expectations have been brilliantly realized. There is no case of genuine ozaena that cannot be at least strikingly and lastingly improved. 2. In many cases the ozaena as such is no longer recognizable; the mucosa is red, fresh, often even hypertrophic. 3. Crust formation ceases partly or entirely. 4. The foetor is so much improved in all cases that in most it disappears entirely, even in the absence of all irrigations. Only in a small minority a faint foetor persists unless irrigations are continued. 5. Some patients even report a return of the lost sense of smell, due, Halle believes, to the fact that the inspiratory air current in consequence of the narrowing of the nasal chambers is now better directed toward the nerve-ends of the olfactory nerve.

Endonasal Lacrymal Sac Operation—Halle's technique is a modification of the original West technique of 1910. In that year West reported his first series of seven cases to the Berlin Laryngological Society. From that time to this a dispute as to priority has raged between West and Halle with reference to one essential part of the operation, the point at issue being the mucoperiosteal flap which, while not a part of the original procedure, is now an element of the technique of both West and Halle. Halle claims (*Zeitschrift fuer Laryngol., Rhinol., etc., Leipzig, 1922*) that he, Halle, was present when West presented his first report; that he recognized the shortcomings of West's operation and that he thereupon devised the flap in question, which West adopted without acknowledgment. This claim West rejects in its entirety. No more need be said here than that the controversy is a regrettable one.

A few general observations may, however, be made. Both West and Halle operate only endonasally. Neither does the Toti nor any form of combined Toti-endonasal operation. Their technique is essentially the same except that Halle cuts out a small window-shaped quadrangle from the flap before bringing it down over the lower turbinate, and counts on replacing the flap so accurately at the conclusion of the operation that its window corresponds with the bony window in the lateral nasal wall facing the sac. West considers that good on paper but not in practice and neither necessary nor advisable. Instead, he amputates the posterior end of the flap in those cases in which on its replacement at the conclusion of the operation it tends to close the bony window. There is this further difference that, while Halle excises only the medial half of the sac, West in recent years has excised it *in toto* in over one hundred cases and is now inclining more and more to the total extirpation as his usual routine.

Whatever may be the points of difference between West and Halle as to the operation, they are in entire agreement on one point, namely, that it is the most difficult of all intranasal operations. That is far more important than all else. When all is said, the ultimate fate of the operation as a generally adopted procedure will depend very much upon the facility with which its technique can be generally acquired. Mosher reports (*Annals of Otology, Rhinology, etc., March, 1923*) that after a series of seven cases, having found it "more difficult, indirect and to a great extent blind," he abandoned it for the combined intranasal and external operation, finding this latter "easier, direct, done by sight, with less danger of opening the orbit." After having studied the endonasal operation with both Halle and West, and having done a series of six operations under West, I am not prepared at the present time to take issue with Mosher. On the contrary I find Mosher's attitude reasonable, consider the question an open one and believe that it remains for the future to fix upon a generally accepted operation of choice.

SUMMARY

The swing is definitely away from the radical external nasal surgery of the past twenty years.

As far as possible all nasal operations should be done intranasally, and not by an external or an oral route.

Establishment of normal nasal respiration is in many cases all that is necessary for the cure of chronic nasal empyemas, especially antral and sphenoidal.

Ozaena, hitherto incurable, is now a curable condition. That is the outstanding achievement of recent rhinological surgery.

The problem of chronic lachrymal disease, long the despair of oculists, has been virtually solved. The key to the solution is the restoration of drainage from the conjunctival sac into the nose. The only question remaining concerns the surgical technique best suited to that end.

209 Post Street.

PRESENT-DAY X-RAY AND RADIUM THERAPY*

By CLAUDE E. PIERSALL, Reno

Since the discovery of the X-ray in 1895 and of radium in 1898, the world has been attentively watching the gradually accumulating evidence of their increasing usefulness in the diagnosis and treatment of disease.

It is now generally agreed that X-ray and radium have established an important place in the treatment, among other diseases, of both benign and malignant neoplasms.

In considering briefly the effects of radiation upon both the normal and pathological cells, the law of Bergonie and Tribandau is quoted:

"Immature cells and cells in an active state of division are more sensitive to the X-ray than are cells which have already acquired their fixed adult, morphological or physiological characters."

This law has been repeatedly verified by many American pathologists. It applies equally to the application of radium. It has been proved, both experimentally and clinically, that insufficient doses of radium tend to render animal tissues hyperemic and only stimulate growth rather than produce cellular degeneration. This phenomenon was perhaps largely responsible for the difference of views among some of the earlier workers with radium. It is because the abnormal cells are more susceptible to the rays than are normal cells that radiation can be successfully used. The more highly differentiated the normal cells the more resistant they are to rays. Brain cells withstand heavier doses than any other tissue.

It was early discovered that radium emits three classes of rays of different degrees of penetration and clinical activity, and which produce different effect upon cellular life. This explains the need of various metal and rubber filters to eliminate the effects of one or more groups of these rays, and to give the highest degree of radiation upon the particular depth or tissue we desire to effect. The development of this knowledge, and the manufacture of radium needles and emanation tubes, which can be inserted directly into the tumor mass, has materially improved the percentage of cures in cancer of the deeper and more remote structures of the body. Likewise the improved X-ray machinery and advanced knowledge of its uses assist the radiologist.

Radiation therapy has been tried for almost all human ills. Its most conspicuous successes have been attained in that class of disease manifested by hyperplasia of soft tissue or lawless cellular proliferation.

The difference in the X-rays and the radium rays and their uses are briefly these: They are very similar, but the radium is the stronger potentiality. It requires no machinery to use it. It is small in size and is more applicable in lesions of the orifices, in crevices of skin, in open wounds or to be buried in neoplasms, while the X-rays require heavy machinery for deep therapy, are not applied at so close a range, and by reason of their

wider radiation are preferable in covering large areas. The two thousand volt deep therapy apparatus is at least a time saver, and it can now be used to advantage in some cases where radium is yet applicable and formerly was preferable.

This age finds radium and X-rays to be the agents of first choice in the treatment of four groups of cases. This classification is not essentially different from that of Lain:

First Group—Angiomas, birthmarks, leucoplakia, keloids, moles, warts, uterine fibroids, or other non-malignant uterine hemorrhages.

Second Group—In inoperable and post-operative cancer and in such diseases as Hodgkin's disease, lymphatic leukemias or lymphosarcomas, radiation is used to give comfort, prolong life, and give hope for an occasional cure.

Third Group—All pre-cancerous lesions such as papillomas, pigmented moles, senile keratomas and leucoplakias, also non-suppurative tubercular adenitis, all premetastatic cancers, especially about the face, and cancer limited to the cervix uteri.

Fourth Group—In this last group might be placed leucorrhea, subacute and chronic, the enlarged thymus glands in children, toxic goiters, chronic and hypertrophied tonsils, soft nasal polypi after surgical removal, cancer of the bladder, cancer of the rectum, and cancer of the esophagus.

Many other conditions are improved or cured by radiation. Some of these are chronic eczema, psoriasis, lichen planus, lupus vulgaris, rodent ulcer, sarcoma, sycosis, acne, favus, actinomycosis, blastomycosis, and hyperidrosis.

Fortunately, however, we have the ultraviolet or actinic rays, which are more effective in many such conditions or are used as an adjuvant to the X-rays or radium, and other well-known remedies. Incidentally, these quartz lamps which give the ultraviolet light are an aid in preventing or healing X-ray burns.

As to dosage for treatment of the diseases named above, there is no set amount of radiation required, because each case may vary as to the degree of the disease, location of the lesion, and also susceptibility of the patient to radiation. Yet we do recognize that certain types of diseases require within certain limits a lethal dose for their particular pathological cell structure. A few examples follow:

An ordinary wart requires about 50 mg.-hrs.—that is, 50 mg. of radium for one hour, or its equivalent of 25 mg. for two hours.

Keloids and birthmarks vary according to the age of both the growth and the patient, as well as the size and nature of the growth. Some keloids require a destructive effect, and others absorption doses. Fibroids and myopathic lesions of the uterus require from 200 mg.-hrs. to 1500 mg.-hrs., depending upon the age of the patient, size of the uterus, amount of bleeding, and other factors.

Cancer of the cervix uteri or the fundus requires from 3500 to 6000 mg.-hrs. within six days' time, followed with heavy crossfire X-ray treatments, given after several weeks interval through several portals of entry.

Contra-indications for radiation therapy are:

Pedunculated fibroids; fibroids causing acute

*Read before the twentieth annual meeting of the Nevada State Medical Association, Reno, September 28th and 29th.

pressure symptoms; those very soft, or over 12 cm. in diameter; any acute inflammatory process, particularly in the tubes or ovaries, and infections, except when in or near some malignant growth.

In melanoepitheloma and melanosarcoma, and carcinoma of the esophagus, only palliation may be expected. There is no satisfactory method as yet for treating malignancy in the gastro-intestinal tract.

In treating any malignancy, that part or organ affected should not be allowed to function, in order to give physiological rest, or, in other words, to stop all irritation. If it is a cancerous uterus, coition is not to be allowed. If in the rectum, a colostomy should be done. In case of breast cancers, for example, pre-operative radiation makes some inoperable cases operable by closing the lymphatics, by producing destruction of the surrounding malignant cells, by producing immunizing substances, and by preventing the grafting of cancer cells with the knife. Such radiation often stops the cancer pain within a few hours. Post-operative radiation to all surrounding lymphatics prevents or retards recurrences of the growth, but is not necessary if pre-operative radiation was sufficiently lethal. In carcinoma of the prostate and bladder, radium tubes or needles are buried at the time of operation. Some favorable reports, however, have been made on the use of radium packs or deep X-ray treatment without operation or implantation of radium. Cancer of the fundus uteri, if known to be localized, is a surgical case after radiation, provided the patient is able to stand a radical removal. Cancer of the cervix is always a radium case.

Sarcoma of the post-nasal space or the tonsil is best treated with radium; in other localities, we advise radiation and surgery.

For osteosarcomas, surgery, X-ray and radium or deep X-ray therapy are advisable. For lymphosarcoma, radiation alone is sufficient. The reason for the high mortality rate of malignant cases is that they are not treated for malignancy until a definite diagnosis is made. A small chronic lump in the breast, a chronic sore or fissure or induration should be treated early as a cancer without a biopsy.

In conclusion it may be said that the leading internists and surgeons realize that radiation therapy is progressively filling a long-needed gap in medicine of both benign and malignant diseases.

Board of Education Assigns Physicians' Work to Technicians—When all physicians are employed and directed by laymen news items like the following (*Journal A. M. A.*, September 22, 1923) will not be interesting:

"The three physicians who for a number of years have been retained by the Board of Education of Belleville regularly to 'inspect' the physical condition of school children, will not be reappointed. Their former duties in this regard have been taken over by a school nurse employed at \$160 a month, which means a saving to the board of \$900 a year. Abandonment of the school physician system, it is said, was due largely to a controversy that arose last year in which the physicians objected to the school nurse making diagnoses. Those who will not be reappointed are Drs. Adolph E. Hansing, Henry Reis Jr., and Charles R. Huggins.

ROENTGEN-RAY THERAPY IN THYROTOXICOSIS; ITS EFFECT AS MEASURED BY THE BASAL METABOLIC RATE *

By J MARION READ, M. D., San Francisco

The feature possessed in common by all of the cases herein reported was a definite increase in the basal metabolic rate, together with other variable signs and symptoms indicating abnormal thyroid function. Many presented the typical Graves syndrome, a few had adenomata with toxic manifestations and some were atypical, or "formes frustes" types. From a therapeutic viewpoint, definite classification is desirable, but in some cases it is difficult. Roentgen irradiation is a therapeutic measure, which seems to have a beneficial effect on a great majority of patients suffering from thyrotoxic signs and symptoms. By distinguishing between the Graves' syndrome and toxic adenoma, considerable progress has been made and more satisfactory results obtained. Most observers agree that the treatment of choice in patients presenting toxic adenomata is surgical intervention. Considering the neoplastic nature of adenomata, excision is the logical procedure, and the results obtained have justified its employment. The situation, in respect to Graves' disease, is not so satisfactory, and there is much controversy over the proper therapeutic course to follow in caring for sufferers with this disease. Some of the factors contributing to this state of uncertainty will be suggested in the course of this discussion, and illustrative cases will be cited.

Since September, 1920, most of the patients receiving Roentgen-ray treatment for thyrotoxicosis at St. Luke's Hospital have had one or more determinations of the basal metabolic rate. During the greater part of this time, an estimation of the rate has been prerequisite to the institution of therapy, and the test has been repeated monthly during the period of irradiation. During the past three years, over fifty patients have received Roentgen-ray exposures to the thyroid, and their cases constitute the basis of this report. Only a few were clinic cases, the greater number being referred by private physicians.

Through the kindness and interest of these physicians, it has been possible to obtain follow-up reports on many of the patients, but absence of basal metabolic rate determinations at the conclusion of treatment in many instances is to be deplored.

The cases have been divided into two classes, namely, Graves' disease and toxic adenoma. Not infrequently, however, a patient presented a clinical picture, together with a history and physical examination, which made classification difficult. This applied particularly to those patients with slight, if any, thyroid enlargement, who complained of nervousness, small loss of weight, and some heart hurry, but who lacked all the classical eye-signs of exophthalmic goiter. The basal metabolic rate in these cases was rarely above plus 45 per

* Presented to the Section on Radiology at the Fifty-second Annual Session of the California Medical Association, San Francisco, June, 1923.

cent, and they responded particularly well to Roentgen irradiation. This type has been referred to sometimes as "simple hyperthyroidism," but the term is objectionable, as it is probably neither "simple" nor "hyperthyroidism."

Standard technique, carried out under the direction of Dr. J. M. Rehfish, roentgenologist of St. Luke's Hospital, has been followed in all cases. In the earlier cases exposures to different portions of the gland were made at weekly intervals, but more recently treatment to the whole thyroid has been administered once a month. This is the technique successfully followed at the Massachusetts General Hospital by Holmes.

The longest period of observation was three years, though reliable histories and hospital records for the past twelve years were available in some cases. Some of the patients are still under observation and receiving treatment, and a future report will be made on the further progress of this work. A more careful study will then be possible, since the X-ray department will not irradiate any thy-

roids without a preliminary estimation of the basal metabolic rate and redeterminations of the rate at regular intervals. Past experience, both here and elsewhere, has shown this to be the only safe policy to pursue.

It is now almost universally conceded that the basal metabolic rate is the most reliable single test in thyrotoxic cases, and its fluctuations are accompanied by subjective and other objective changes in the patient's condition. The regularity with which the pulse rate, for example, may follow changes in the metabolic rate is illustrated in Figure 4. For these reasons the basal metabolic rate has been used as a criterion of change or cure, though the patient's own statement or that of the attending physician as to condition has been accepted where no determination of the rate was obtained at the conclusion of treatment. A few patients ceased treatment and were lost from observation before the rate returned to normal, but in several such cases reliable follow-up reports were obtained.

Figure 1 shows the course of seventeen patients,

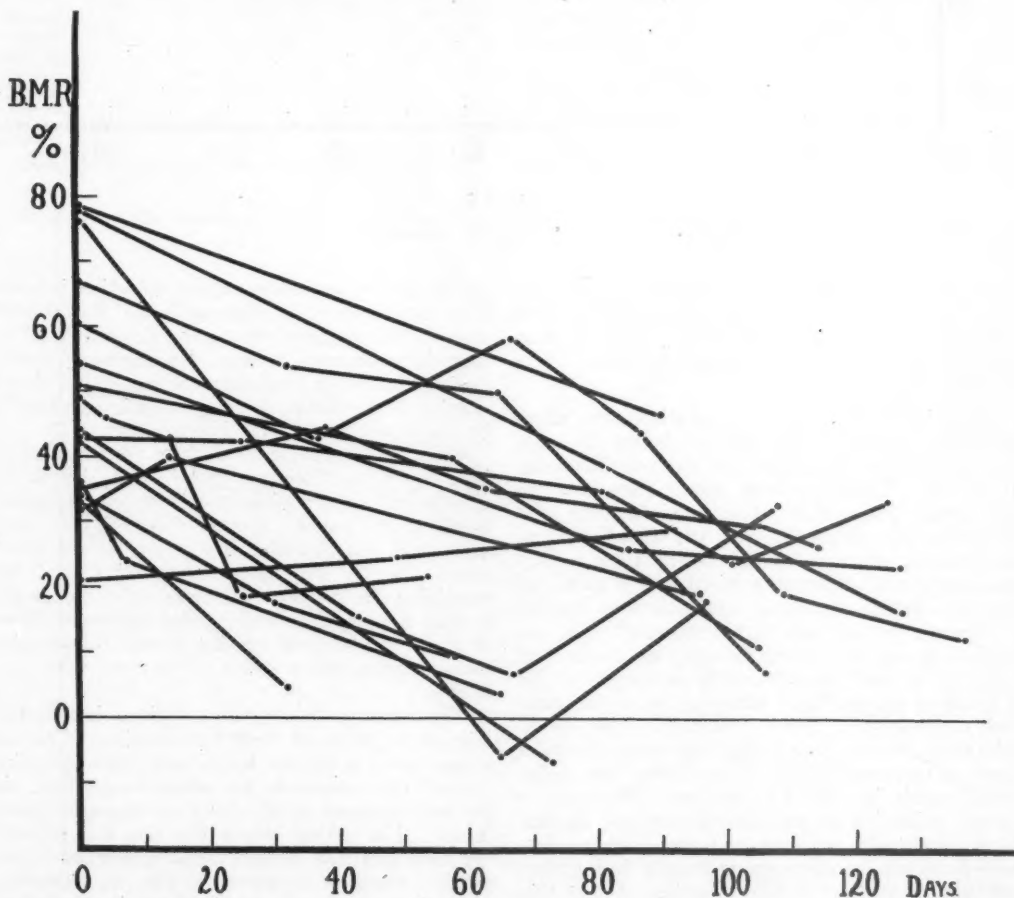


Figure 1

Course of seventeen patients with Graves disease treated with Roentgen ray. Estimations of the basal metabolic rate were made at monthly intervals in the majority of cases. Five have come down to less than plus 10 per cent in less than four months; five others have reached less than plus 20 per cent in the same time. Four of those with rates remaining above plus 20 per cent at the last observation have since reported themselves well. Three with rates above plus 20 per cent are still under treatment.

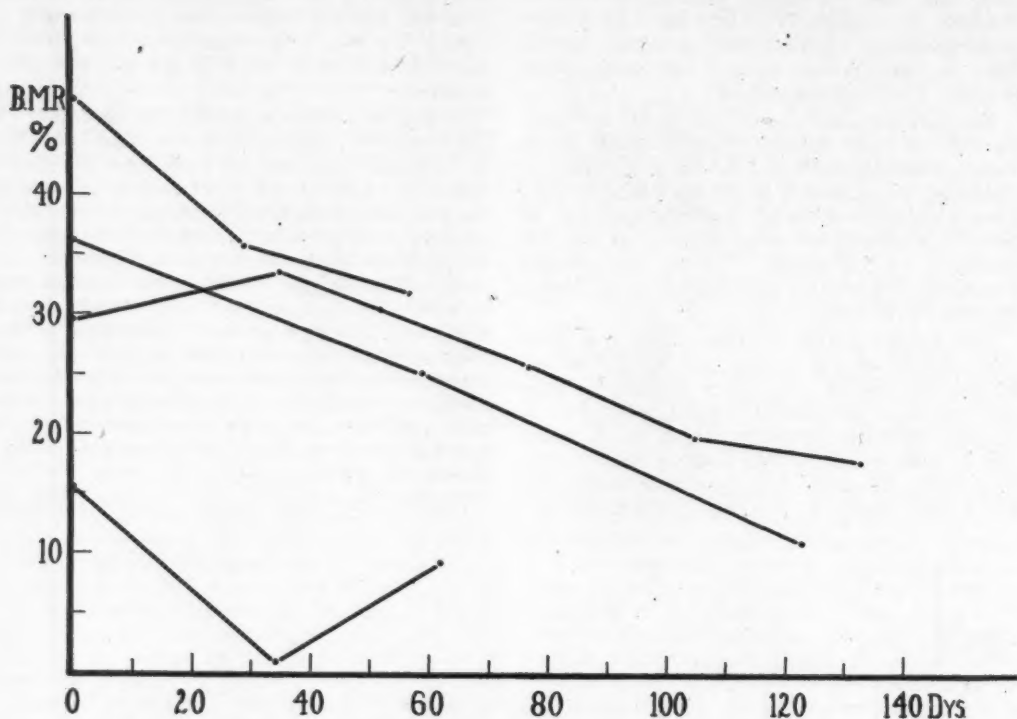


Figure 2

Course of four patients with toxic adenomata treated with Roentgen ray. Two are relieved of their toxic manifestations; one is improved but not well, and one is still under treatment.

who were observed for four months or less. It may be observed that most of them reach less than plus 20 per cent within that time. Four of those who do not have reported themselves cured. Five are still under observation.

Attention is directed to the two instances where the basal metabolic rate dropped below the zero line at the first estimation of the rate following treatment. These are both recent cases and are still under observation. One received three and the other four treatments over the whole gland at an interval of three weeks rather than weekly treatments over different portions of the gland, as was the former technique and that used in the greater number of cases herein reported. The reduction in rate was rather startling and more than could be ascribed to spontaneous improvement, for it occurred too rapidly. Although no myxoedemas had resulted from X-ray treatment alone up to this time, it was feared that the more intensive form of treatment might be producing that undesirable result in these two patients. However, a second estimation of the rate in one case showed it to be plus 18 per cent, and the other patient, who is out of the city, reports herself feeling fine, and will report for a determination of her rate upon returning to San Francisco.

Full realization of the natural course of Graves' disease has raised some skepticism in the writer's mind as to what part the Roentgen ray really

played in the improvement and reduction in metabolic rate observed in these patients. But observation of the two cases cited above has convinced me that, in some cases at least, Roentgen-ray irradiation is capable of producing marked and rapid reduction in the metabolic rate which is accompanied by corresponding general improvement.

Only six patients with definite adenomata have been treated. Two are cured, two showed no change and were advised to submit to surgical removal of the tumor. One of these has been operated upon, but the other has so far refused operation. One is still under observation, and the remaining one has been lost from sight, though she showed improvement while under treatment. Two of these patients had uterine fibroids, illustrating an association which seems to be more than accidental.

The course of four of these patients is shown in Figure 2. Two of these had fibroids. The one whose curve is highest has ceased uterine-bleeding under X-ray treatment, but refuses surgical aid for the toxic adenoma which shows no regression under X-ray. The patient whose last rate was plus 18 per cent also had fibroids, which have been successfully removed subsequent to the last estimation of her basal metabolic rate, and she is reported as being in excellent health and without thyrotoxic signs or symptoms. The patient whose initial rate was only plus 16 per cent had a large adenoma of the right lobe, with definite toxic symptoms. One

irradiation produced the drop in rate noted and a decrease of two centimeters in the neck circumference. These were accompanied by abatement of subjective symptoms.

TABLE I

Fifty Thyrotoxic Patients Treated with Roentgen Ray

	No. of B. M. R. Tests			—Results—				Prior Treatment			Subsequently Op- erated Upon....
	Two or More....	One.....	None.....	Cured.....	Improved.....	No Change.....	Not Known.....	Remaining Under Treatment.....	Surgery.....	X-ray.....	
Graves' Disease	34	5	5	19	9	7	2	7	3	1	8
Toxic Adenoma	4	1	1	2	1	1	1	1	..	..	1
Total	38	6	6	21	10	8	3	8	..	..	9

TABLE II

Thirty Patients Treated Surgically

	Basal Metabolic Rate		Previous Treatment		Deaths	Mortality Pct.
	Re-recorded	Un-recorded	X-ray	Surgery		
Graves' Disease	12	1	6	1	3*	23
Adenoma	2	1	..	..	..	..
Cyst	1	2	1	..	..	..
Unclassified	4	7	..	..	1	9
Total	19	11	7	1	4	13

*One patient died three months after double ligation.

Table I summarizes the result of Roentgen irradiation in fifty thyrotoxic patients. Forty-three were treated at St. Luke's Hospital, and the records of seven are from private practice and the Stanford medical wards at the San Francisco Hospital. There were no deaths and no myxoedema in cases treated solely by Roentgen ray. Only one patient, whose initial basal metabolic rate was 112 per cent above normal, was kept in bed more than a week or two. About half of the patients followed their usual occupations, although rest was advised and they were warned against fatigue.

Only approximate accuracy in the estimation of results can be attained. In every case where it was possible, the statement of the patient or attending physician was used as a basis. Experience has taught the writer to be very cautious in saying a patient with exophthalmic goiter is cured. None so classified in this report, however, have since had a recrudescence. The cases indicated as showing no change during X-ray treatment were so classified, because they were operated on before treatment had been persisted in long enough to produce marked improvement. Even these patients showed improvement in most cases, but acceptance of the attending surgeon's estimate of the value of Roentgen irradiation has made the classification of "no change" seem advisable. It at least affords more excuse for operation.

Figure 3 shows the metabolic rate changes in nine patients who were operated upon. One re-

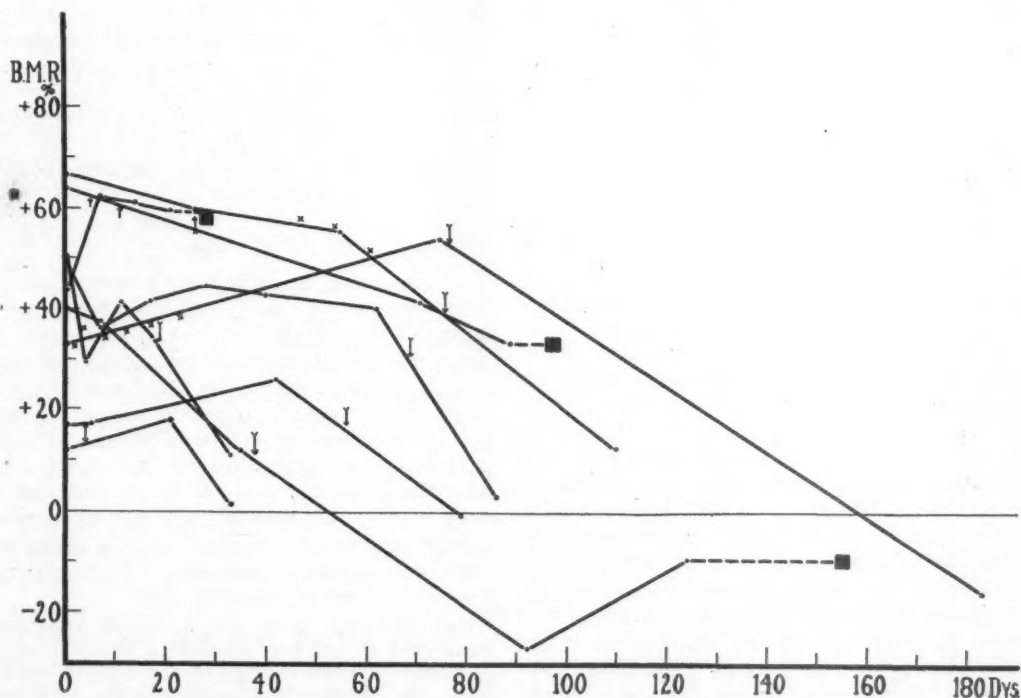


Figure 3

Course of nine patients with Graves' disease submitted to operation. Large arrows indicate sub-total thyroidectomy, small arrows ligations. X indicates Roentgen ray treatments which four of the patients received prior to operation. Black squares indicate death. Both patients whose rates dropped to points below the zero line had received Roentgen ray exposures before operation, and both developed myxoedema after operation. One of these two subsequently died.

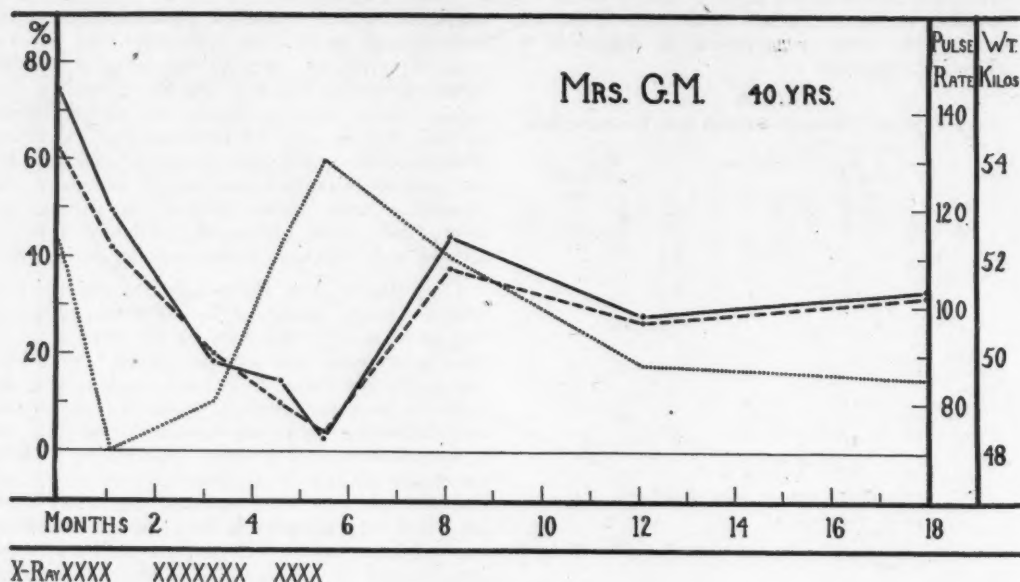


Figure 4

Course of patient Mrs. G. M., 40 years of age, observed for one and a half years. Solid line, basal metabolic rate. Broken line, pulse rate. Dotted line, weight in kilos. This patient had had a sub-total thyroidectomy three years prior to the date of the first estimation of her basal metabolic rate, which was plus 74 per cent.

ceived only double ligation, with a slight drop in the rate, but death supervened three months later as a result of thyrotoxicosis, though the metabolic rate was only plus 33 per cent eight days before death. A toxic psychosis was a marked feature in this case. There were two other deaths, one occurring the day following operation on a patient whose basal metabolic rate was plus 59 per cent. Most of the patients showed rates very close to normal limits a few weeks after operation. Two had rates below minus 10 per cent. One of these had a prior lobectomy, but still presented thyrotoxic signs and symptoms, having a rate of plus 35 per cent when he entered the hospital. Under rest in bed and X-ray treatment, this rate fell to plus 12 per cent by the seventh week, which was thought to be a propitious time for removal of the remaining lobe. The day following operation the patient had a tetanic seizure, which recurred along with convulsions and periods of unconsciousness up to the time of death. He lived for four months after operation, during which time his basal metabolic rate fell to minus 27 per cent, but was raised to minus 11 per cent by administration of thyroxin.

During the period covered by this study there were performed twenty-nine thyroidectomies and two ligations on thirty patients in St. Luke's Hospital. Table 2 gives the complete data. These data include the cases illustrated in Figure 3, these being the only ones whose basal metabolic rates had been estimated before and after operation. It may be noted that there were thirteen cases of

exophthalmic goiter and three of toxic adenoma, and that three out of the four fatalities were in this group. The other death resulted from hemorrhage at operation on a non-toxic goiter. The operative mortality for all classes is 13 per cent, and for thyrotoxic cases a little more than 18 per cent. This series is too small to warrant any conclusions, but it is probable that the average mortality rate among thyrotoxic patients treated surgically is between 15 and 25 per cent, except in such clinics as Crile's and the Mayo's.

In evaluating the different therapeutic procedures employed in dealing with thyrotoxicosis, especially Graves' syndrome, there is a proneness to forget that spontaneous cures are frequent and that there is a strong tendency for the disease to run a fairly definite course marked by periods of improvement alternating with recrudescences of more or less severity. Recrudescences do not occur in some cases, but they seem to be the rule and it seems difficult to prevent them by any known method of treatment, including sub-total thyroidectomy and Roentgen irradiation. An illustrative case will be cited to make this clear:

Case 310—Mrs. G. M., age 40, Italian housewife, about eleven years ago consulted a physician, who diagnosed exophthalmic goiter and advised operation. She declined and called another physician, who also advised surgical intervention and refused to treat her unless she consented to operation. She persisted in her request for medical treatment, and the second physician consented to try a substitute for surgery. He treated her with camphor mono-

bromate and ergot, and to his surprise she recovered. In six years she again consulted him and presented the typical picture of Graves' disease. Operation was advised and on February 27, 1918, the right lobe, isthmus, and portion of the left lobe were removed. She made a satisfactory recovery. Because her trouble had first come on with child-bearing, she was advised not to become pregnant again following operation; but, believing she was cured, in 1922 she again became pregnant and experienced a return of all her old trouble. At this time she came under my observation, being referred for an estimation of the basal metabolic rate, which proved to be plus 74 per cent. She then presented the classical signs of Graves' disease.

Figure 4 shows her course from that time to the present. She aborted at six months, and was given X-ray treatment. The metabolic rate returned to normal in five months, being accompanied by a gain of fifteen pounds in weight and a decrease in pulse rate from 132 to 72. Tremor, goiter, and eye-signs also disappeared. The patient was again cured. Three months later the rate was plus 44 per cent, with a subsequent drop as shown on the chart. She then had some teeth removed under local anesthesia, which resulted in so incapacitating her that she was confined to bed for three months. The attending physician ascribed her condition to cocaine poisoning. The last estimation of her metabolic rate was on September 25, 1923, when it was plus 33 per cent. She said then that four months prior to this her heart beat very hard and fast, she lost weight, and was so nervous she could not have cooperated enough to have a test made to determine the metabolic rate. Since she was a practiced subject by this time, one may assume that the rate must have been much higher at about fourteen months in Figure 1 than the straight line connecting the last two observations indicated.

This case illustrates the influence of pregnancy on Graves' disease, as well as the tendency of the disease toward recrudescence. Furthermore, this patient was "cured" once by medicines and rest and again by surgery and the rest incident thereto, and a third time by Roentgen rays. In spite of all this she refuses to remain cured, but continues to present the signs and symptoms which we call thyrotoxic. Obviously, the cause of her disease has not been removed. It is interesting to note that this patient presents no evidence of myocardial damage. There is no irregularity of pulse and no signs or symptoms of decompensation.

CONCLUSIONS

1. The Roentgen ray seems to be effective in reducing the metabolic rate, together with the toxic signs and symptoms in thyrotoxic patients.
2. Determination of the basal metabolic rate affords the best check on the result of therapy and should be made routine in treatment with X-ray.
3. A period of three to six months is necessary to secure marked improvement or return to normal. The higher the initial rate the longer must be the period of treatment.

4. No patients are made worse by irradiation and no myxoedemas resulted therefrom.

5. No deaths have occurred in this series of fifty cases in patients treated with X-ray alone.

Relation of Pruritus of Anus to Chronic Diseases of Abdominal and Pelvic Viscera—In many of those chronic diseases of the stomach associated with dyspepsia, chronic gastritis, J. F. Montague, New York (Journal A. M. A., November 17, 1923), asserts there is added to the clinical picture the condition known as anal pruritis. This is particularly true in cases associated with much gastric fermentation. In these cases, a cure or relief of the gastric condition often brings about a parallel relief in the pruritus. Medical literature reports the association in some cases of carcinoma of the stomach with pruritus; and many other chronic diseases of the gastro-intestinal tract, such as chronic colitis, chronic constipation and fecal retention, have also been observed to have an apparent relation with the causation of pruritus of the perineum. In a closely similar manner, an identical apparent relation has been seen to exist in some patients with chronic diseases of the genito-urinary tract. As examples of this, chronic endometritis, chronic prostatitis, hypertrophied prostate and chronic urethritis may be mentioned. Of the other chronic visceral diseases which at times appear to bear a relation to this condition, obstructive derangements of the liver, such as hypertrophic cirrhosis of the liver, are notable instances. Chronic cholecystitis, chronic nephritis, cystic calculus and neoplastic growths of the liver have each contributed their share of examples of this relation to pruritus of the anus or perineum. J. F. Montague believes that all cases of pruritus of the anus can be divided clinically into two classes: The one, a direct pruritus (pruritus ani) due to the direct irritation of the peripheral nerve endings in the pruritic zone, in which cases the source of irritation actually causes a primary pathologic condition whose direct nature can be demonstrated by the abolition of pruritic sensation by local anesthetization or superficial neurotomy; the other, an indirect pruritus (anal pruritus) due to the perception of the pruritic sensation which in consciousness is referred to the pruritic zone, an area which is at the inception of the pruritus devoid of any pathologic condition at all. This phenomenon is due to the transference of an irritable stimulus from the visceral afferent nerves to a normal somatic afferent nerve channel or pathway, and the consequent misreference or error in localization of the sensation. This indirect pruritus, although devoid of local lesions at its inception, induces a desire to scratch which results in the pathologic changes previously noted; namely, first, a traumatic, chronic dermatitis, and in many cases, secondly, an infective chronic dermatitis. These secondary pathologic changes in the tissues of the pruritic zone lead to an added component of direct pruritus. As a matter of clinical fact, sooner or later in all these cases of indirect pruritus there is superimposed the element of direct pruritus. In this type of pruritus, local therapeutic measures are not indicated unless the patient's efforts at relief, such as scratching and rubbing, have induced a direct pruritis either of a mechanical or an infective nature.

MENINGITIS OF OTITIC ORIGIN*

By J. FRANK FRIESEN, M. D., Los Angeles

In presenting the subject of otitic meningitis, I am limiting the scope to the recoverable types of meningitis caused by middle ear infections. The meningitis of meningococcic origin is excluded.

Leptomeningitis following a middle ear infection, producing all of the typical meningeal symptoms, was at one time regarded as a hopeless condition, but the last few years the prognosis has become more favorable in the light of so many records of authentic recoveries.

It is only more recently that a differential diagnosis between a diffuse purulent meningitis and other forms has been accurately determined.

In analyzing these recoverable types of meningitis more closely, we first recognize the fact that they are secondary to meningeal irritation or an intracranial infection, usually of otitic origin.

If the involvement is extradural and the infection does not extend beyond the dura, a localized pachymeningitis results, in which the pia and arachnoid have escaped actual infection and no pus or bacteria are found in the spinal fluid. The cause of this type of meningitis is a meningeal irritation from an adjacent infective focus. Eagleton speaks of these cases as a "protective meningitis." Plautt and Schottmuller have classified them as a "sympathetic meningitis," and Sharp, as "serous meningitis."

If an infection is slowly spreading into the subdural spaces in the course of a middle ear or mastoid disease, then there is set up sufficient tissue reaction to wall off and limit the suppurative inflammation in the pia and arachnoid. This circumscribed or localized purulent meningitis may follow practically the same course clinically as a diffuse process.

During the last year several patients with otitis meningitis followed by recovery, have come under my observation. I will give a few brief case-reports, which possibly will convey a clearer impression of the localized or circumscribed form of meningitis than the description.

Case 1—B. G., female, 8 years of age, was admitted to the Los Angeles General Hospital, August 20, 1922, with the diagnosis of a chronic left middle ear infection and an acute intracranial invasion.

The ear had been discharging intermittently for five years. A year ago she had an operation for the removal of an aural polyp; also the tonsils and adenoids.

Her symptoms on admission were pain in the left ear, headache, and restlessness of several days' duration.

The examination disclosed a definite cervical rigidity with a suggestive Kernig. A lumbar puncture was done, the spinal fluid was turbid and under increased pressure. Microscopic examination revealed numerous puss cells, few lymphocytes, but no bacteria. The culture was sterile. Another examination of the spinal fluid five days later gave the same report.

The child was operated upon. The left mastoid filled with a large cholesteotoma. Further exploration revealed an extra-dural abscess.

The patient had a stormy career during her stay in the hospital, but finally made a complete recovery.

Case 2—M. M., a male 18 years of age, was ad-

mitted to the Los Angeles General Hospital October 2, 1922, with a history of pain in the left ear for two weeks. The examination disclosed an acute left mastoiditis with the classical symptoms of meningitis such as stupor, rigidity of the neck, and a positive Kernig.

The report of the examination of the spinal fluid was as follows: Pressure of the fluid, slightly increased. Slight turbidity, 1226 cells per cmm., globulin negative. The fluid did not reduce Haynes solution. Direct smear showed numerous pus cells, but no bacteria. Culture showed no growth.

A simple mastoidectomy was performed and pus found in the mastoid antrum, the mastoid entirely sclerosed, and all cells absent. The dura and sinus were uncovered, with no evidence of further involvement. A smear and culture of the pus showed the staphylococcus albus. A blood culture proved negative.

The patient became worse after the operation, and all of the meningeal symptoms were more marked. He was comatose at times and difficult to arouse. Several spinal punctures were done at regular intervals, and quantities of fluid varying from 20 cc. to 45 cc. removed at one time. The patient made a perfect recovery and was discharged October 29.

Case 3—F. A., a girl, 9 years of age, entered the Los Angeles General Hospital January 16, 1923, acutely ill with all signs and symptoms of a cerebrospinal meningitis.

The left ear was discharging, and she had acute mastoiditis on the same side.

A lumbar puncture was done and 20 cc. of cloudy fluid under increased pressure removed. Fifteen cc. of anti-meningococcic serum was introduced by gravity. Examination of spinal fluid; turbid, globulin positive 1500 cells per cu. mm. A smear showed a few grams positive cocci (staphylococci) (apparently contamination); also a few pus cells. A subsequent culture proved to be sterile.

A simple mastoidectomy was performed. The mastoid cells were filled with pus. The sinus and dura apparently were not infected. A culture of the pus from the mastoid showed a growth of non-hemolytic streptococci.

The patient made an uneventful recovery, and was discharged two weeks after entering the hospital.

Clinically, these patients have the classical picture of a true meningitis, and the symptoms may vary from the mild to the severest type, such as the elevation of temperature, headache, drowsiness, stupor, rigidity of the neck, Kernig's sign, etc.

Mygind, of Copenhagen, reports a series of 210 cases of otogenic meningitis, with a recovery of 28 per cent after operation. Chronic suppurations of the middle ear were decidedly more frequently the cause of the benign (recoverable) meningitis than that of the malignant (fatal). In a chronic case there is a slow walling-off process going on, and the prognosis is decidedly better than in the acute cases. Streptococcus infection was predominant in the benign cases, while the pneumococcus infection played a comparatively important part in the malignant cases.

The lumbar puncture is very significant. As a rule, in the benign, or recoverable, cases the cerebrospinal fluid is clear or slightly turbid, with moderately high pressure. The cells are usually polymorpho-nuclear, and there is a moderate increase in the albumin content. Bacteria are usually absent.

If there is a known or suspected middle ear infection, together with the findings of a spinal fluid as has just been described, one must consider the possibility of an epidemic, tuberculosis or syphilitic

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meningitis, having no causal relationship to the ear suppuration.

The malignant or fatal cases of meningitis reveal a turbid fluid with very high pressure, and bacteria are usually present.

Yet there are exceptions to this rule, and cases have recovered where the turbid cerebro-spinal fluid showed the process of bacteria. Gradenigo has reported two cases of typical meningitis that showed the presence of staphylococci in the spinal fluid, with recovery after operation.

If bacteria are found to be present on culture of the spinal fluid, this should not be held as absolute proof unless confirmed by a subsequent lumbar puncture and culture.

On the other hand, the absence of bacteria in a turbid spinal fluid does not rule out a diffuse leptomeningitis. Yerger reports eleven cases of diffuse leptomeningitis seen at necropsy in which cultures had been made, and only four had revealed the presence of bacteria.

Recent investigations have proven that the cerebro-spinal fluid is a circulatory medium, and the character of the fluid obtained by lumbar puncture does not always indicate the state of the leptomeninges in the spinal canal.

Most observers believe that these cases of recovery have belonged to the circumscribed form of purulent meningitis, and that diffuse leptomeningitis is a hopelessly fatal disease which the surgeon is powerless to relieve.

From a bacteriological point of view, the pneumococcus leptomeningitis is regarded as the most fatal type. This pneumococcus is often described as the streptococcus mucosa capsulatus. The fulminating character of this type is usually due to a secondary blood sepsis. The streptococcus and staphylococcus meningitis are much more common, but not so virulent. The least virulent is the meningococcic meningitis.

When an ear infection reveals meningeal symptoms, a lumbar puncture should be made for diagnosis, and where there is an increased intracranial pressure, the puncture should be repeated for therapeutic purposes.

Where the bacteriological and clinical diagnosis of the meningitis has not been firmly established, an intraspinal injection of anti-meningococcic serum should be administered at the time of lumbar puncture, especially if there is any suspicion that an epidemic meningitis may co-exist with the aural lesion.

If the history and examination of the ear or mastoid reveals an acute or chronic suppuration, the mastoid should be thoroughly exenterated, the dura and sinus uncovered, and drainage established. In the majority of cases the path of infection travels by local extension to the sinus and dura, with a resultant sinus-phlebitis and dural infection.

In old aural suppurations a cerebral or cerebellar abscess is a possibility, with a secondary meningitis. The labyrinth may be the pathway for the meningeal involvement.

At times it is difficult to establish a path of infection, either at operation or at necropsy.

The successful cases reported in the literature have established the fact that meningeal drainage

will save many, which otherwise would terminate fatally. Especially is this true when the route of intracranial invasion is through the tegmen or inner table of the mastoid. When the disease spreads through the labyrinth, the results are not so good.

It is my opinion that, even in apparently hopeless cases, surgical intervention is justified on the ground that the evacuation of pus from the intradural spaces, together with relief of tension offered by lumbar puncture will occasionally result in the recovery of cases which would otherwise terminate fatally.

Chapman Bldg.

INDIVIDUALITY AND ENVIRONMENT AS ETIOLOGICAL FACTORS IN THE PSYCHONEUROSES*

By CHARLES E. NIXON, M. D., San Francisco

The progress of medical practice has been notably retarded by the failure of some physicians to realize that the primary object of their attention should be the individual and not the particular anatomical or physiological disturbance from which the patient is apparently suffering. How frequently some isolated deviation from the average is seized upon with the greatest enthusiasm and on this finding is predicated the patient's entire difficulty. "High blood pressure," "anemia," "murmur," are terms that too often give complete satisfaction. As new laboratory methods and refinements of physical examination are added to the already lengthy examination routine, the individual is more and more lost sight of in the frantic search for physical or objectively demonstrable abnormality. It is not uncommon to see long records where almost every known procedure in medical practice has been done and not one word written about the patient as an individual—as to his reactions as a whole.

The failure to recognize this broader viewpoint and thereby to be of infinitely greater service to those seeking our help has been due partly to the unfortunate conception conveyed by the terms "organic" and "functional." If, on examination, a condition dignified by the title of "organic" is found the physician regards it as being important and demanding attention; however, if the difficulty is one of the so-called "functional neurosis" group the patient is not infrequently told that there is nothing the matter with him; to "forget it" or, at most, he is told to get out for some exercise and is given some injections of iron. The student is thoroughly impressed with the dictum "never make a diagnosis of a neurosis until you have ruled out all possible organic diseases"; he is taught to regard laboratory findings, especially the more complicated tests, as being of the greatest importance; indeed, so awed is he by these mysterious reactions that the history and physical examination are hastily passed over in the frantic rush for the laboratory reports.

This narrow and altogether erroneous conception will persist until physicians learn that there are three things to be considered in dealing with a patient and, while in this paper I am referring especially to the psychoneuroses, this applies as well

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to every other field of medicine. The three factors entering into every case are the *individual*, the *environment*, and the *adjustment* of internal relations to one another and to environment.

Man is a highly complex organism in which all structures are more or less closely related. *Individuality* is the result of the particular form, function, and grouping of the various organs and tissues. Personality has been the term commonly used to express the makeup of a person, but because this word is thought of more in reference to the psychic aspect I have suggested the use of the term *individuality* to convey a more comprehensive conception expressing thereby the physical and mental status and the reactions of a given person. People are grouped on the basis of physique as robust, frail, obese, slender, muscular, or asthenic; from the intellectual standpoint, as very superior, superior, normal, or dull. Likewise, groups are made according to the emotional, endocrine, moral or social status or to the possession of unique traits. It is, however, the particular combination of all these phases of a person that gives him his individuality and accordingly no study of a patient is complete without a consideration, separately and as a whole, of all of these factors. It is just as important, perhaps more so, to know that man is temperamental, unsocial, egocentric, timid, inclined to excessive worry, impractical, of mediocre mentality, or has a feeling of inferiority as it is to be cognizant of a blood pressure above the average or of an existing arteriosclerosis.

Among people who are considered as "normal" and who are economically and socially independent we find great variation, and even abnormality, of structure and function. Health does not depend upon the absence of all abnormality, but upon an adequate adjustment of the various structures and functions, and upon the individual's success in maintaining his adjustment to his environment in spite of the pathological condition. Thus, a person may have a heart lesion, but if the heart is able to compensate for this so that internal relations are not disturbed, the individual leads his usual life; likewise a man may be of the "shut-in" type or egocentric or dull and yet be able to compensate for these peculiarities and so lead a normal life. The crux of the situation is not the presence of some abnormality but whether there is an adequate adjustment of internal and external relations. To use the words of Herbert Spencer, life is "the continuous adjustment of internal relations to external relations."

Using again the heart lesion as an illustration, the involvement of the organ may be so severe that it is not able to compensate for the additional load thrown on it, and the patient is unable to carry on his usual activities; in the familiar phraseology of pathological sociology, he is unable to adjust himself to his environment. If further internal adjustments are impossible then the environment must be modified.

The application of this conception of disease and its treatment is especially applicable to the psychoneuroses and is essential to a proper understanding of these conditions. The etiology of the psychoses

and neuroses has been attributed to almost everything—infections, intestinal kinks, anemia, enlarged prostates, heredity, poor environment, domestic or business troubles, mother or father fixation, sexual repression, lack of sexual repression, and so on ad infinitum. Unquestionably, any one of the conditions mentioned may be an important etiological factor, but it is not the existence of the condition per se that causes the psychosis or neurosis; the disturbance develops because the *individuality* is such that there is difficulty in making an adjustment to the environment. Stewart Paton has suggested that the term "insanity" be discarded and the term "maladjustment" be used instead, for, as he aptly says, "Disease is an imperfect adjustment of which mental disorders are a special but not specifically different type."

We are all potential psychoneurotics; most of us do not actually become such because our defects of individuality are not so marked, or our environment is so sufficiently simple that we can adjust ourselves to our environment. In some the margin of safety is very great—they are endowed with good bodies and minds, they have a stable personality, their instincts do not bring on too many conflicts—in other words, the individuality is so good that the environment may be very bad without the development of a psychosis or a neurosis; in others, however, there are personality defects, or physical or mental stigmata that make necessary a very suitable environment to prevent the manifestation of such a disturbance.

Three illustrations, in the way of brief case records, will perhaps further elucidate this viewpoint.

A middle-aged man with a large family had been economically independent until the last year; he had recently become depressed, anxious and nervous; he stated that it always seemed he was just barely making a go of things before the present trouble, and in the last year he found his circumstances in life too much for him. The psychiatric examination showed a mental age of ten years, and the physical examination revealed a moderate arteriosclerosis with a comparatively high blood pressure. Because of a rather good personality and a good physique, he had previously been able to adjust himself to his environment in spite of the handicap of intellectual inferiority, but with the additional stress of an arteriosclerotic condition there came a break, with the resultant psychoneurosis. His usual occupation carried with it a fair amount of responsibility, so the most essential part of this man's treatment was to have him engage in work with little responsibility and not too strenuous from a physical standpoint—in other words, to modify his environment.

A highly successful engineer had an important position in a large corporation. While under considerable strain he developed an attack of manic-depressive insanity. On recovery he returned to his former work and had another episode, and on recovery again returned to his position and a third time had a mental upset. After this last attack he gave up mine engineering and took a position as a driver on a milk-wagon. He has been doing this work for several years without a recurrence of his

trouble; another example of a too complex environment being a factor in the development of a psychosis.

The third case is a man, age 35 years, with a wife and two children. He was artistically inclined, but lacked technical training to make a living as an artist. He was impractical and had other personality defects that made him an economic dependent. For years the Charities had contributed largely to the family support, making up the deficiencies in the wife's earnings. While the wife was working he would care for the children, playing much as a child and puttering with his paintings. As a result of the conflicts arising from his failure to support his family or even to make an attempt at any practical work, he developed a severe neurosis, and as the result of his insistence that he had pulmonary tuberculosis together with some indefinite signs he was given numerous physical examinations, each one aggravating his neurosis. To make this brief I have to omit many interesting details, but the ending was the adjustment of internal relations or the modification of his individuality by psychotherapy, giving him some insight into his condition and causing him to recognize that he could not earn a living through his art work, but that it was incumbent upon him to support his family through any work he could find and do, his environment was simplified by the supervision and interest of a very intelligent social service worker; with the exception of one break following a mild attack of influenza he has entirely supported his family for several years through his employment on a humble job. He has been encouraged and helped with his painting, with the hope that later some work may be found where his artistic ability may have further development and outlet.

(Flood Building.)

DISCUSSION

Walter C. Alvarez, 177 Post Street, San Francisco—Some physicians do not use laboratory or Roentgen-ray help because it is not available or because their patients are too poor. Others do not use these tools because they do not know that some of them exist; they do not know how to handle them, or what they are for. On the other hand, there are many pseudo-scientific individuals who, especially when a consultation is pending, like to order blood cultures and counts, blood chemical work, metabolism determinations, Wassermanns, stool examinations, and Roentgen-ray plates of everything in the body. Sometimes, for lack of any directing mind, the particular procedure which would easily make the diagnosis is the only one which is omitted. Thus, an acquaintance of mine with leukemia came to me with a hundred dollars' worth of Roentgen-ray and laboratory reports. His diagnosis had been missed by a number of physicians because, through some oversight, a blood-smear had not been looked at.

The writer never likes to order any laboratory or Roentgen-ray examinations until a careful history has been taken and perhaps the physical examination made. The diagnosis may then be clear and the patient may be saved further expense. If doubts remain, the laboratory procedures should be designed to clear those doubts. Then the essential thing is to follow clues as they appear. To illustrate: A typical neurasthenic whose only complaint was lack of "pep" gave no clues from history-taking or from the physical examination. The urine, however, showed some white and red cells. Where did these come from? Massage of the prostate showed

pus, but no red cells, so plates of the kidneys were taken and they showed two large "silent" stones.

The true physician must be a splendid student and a rapid reader to absorb much of many sciences; he must have wonderfully good judgment to sift the evidence, to pick out the essentials and to decide what is best to do with the individual; he must have great human sympathy, kindness and friendliness or he will never bother himself about environmental problems; and finally, he must be a physical giant or he will be too tired most of the time to attempt anything but a snapshot diagnosis and a palliative treatment. Nixon's appeal is a good one, but it has always seemed to me that such exhortations must go unheeded so long as we physicians partake so largely of the mental, moral, and physical weaknesses of humanity. To be sure, as Stevenson says, we share "as little as any in the defects of the period," but some of us haven't Class A intelligences (only four out of a hundred men in the American white draft had); some of us are lazy, and almost all of us find it burdensome and annoying to think. So long as we are made that way we will continue trying to delegate the making of the diagnosis to the laboratory man and the roentgenologist.

Henry S. Whisman, University of California Hospital, San Francisco, Cal.—Modern medicine has been dominated by the materialistic dogma. According to this formula there must be a correlation of the symptom-sign complex with an organic, mechanically demonstrable deviation from the norm. This has meant the intensive study of the function of the part to the exclusion of the function of the whole, with an utter disregard of the principle of integration. Hughlings Jackson long ago spoke of the physico-chemical, the sensori-motor, and the psychic or symbolic levels, each transcending the other through integration, with a final expression in the behavior of the human being as we know him. The clinical picture of disease must then be a reaction, not of a single part or organ, but of the organism as a whole. Every individual has his own peculiar type of reaction, conditioned by inherited, constitutional factors on the one hand and his life experiences on the other. The result of a defect of adjustment is always a symptom constellation which is determined by the extent and character of the defect and the reaction-type of the individual. The defect may be at the physiological level, and thus a part-disorder, so-called organic disease, or it may be at the social psychological level, a maladjustment of the person to his environment. The clinical picture may be, and often is, the same. A defect of adjustment in the social or psychological sphere is naturally and automatically, and usually unconsciously, expressed by discomforts and inadequacies in the physiological realm. The keynote to a correct estimation of the situation is, therefore, not only a careful survey of the status of the various organs, but imperatively also a study of the personality with its reaction tendencies.

When the defect has been found to lie in an organ, demonstrable by some instrument of precision, physicians have always been ready to attempt a readjustment by pharmacological or mechanical measures. They have been less ready, and often unwilling, to look upon the symptomatology as a possible expression of a defect of adjustment of the individual as a social unit. The physician must broaden his viewpoint and extend the scope of his investigations and therapeutic efforts in order to meet the problems of psychobiological medicine. A sizing up of the situation demands no complicated technique. A few common-sense questions designed to bring out the nature of habitual reactions to the ordinary, concrete situations of life, incorporated in a paragraph in the anamnesis, would in most cases supply the data. Even the casual observer of the signs of the times may readily see that these are real problems and since they come so largely within

the sphere of activity of the physician, it is only right that he, rather than the charlatan, should make the effort to meet them.

Clifford W. Mack, Livermore Sanitarium, Livermore, Cal.—The writer of the article on the psychoneuroses is dealing with a phase of medical practice that should be of the utmost concern to the medical profession today because ignorance or neglect of the subject will result in many failures that will be to our discredit. In these times of charlatanism, cults and near-doctors of all sorts, many of these psychoneuroses under the guise of other diagnoses will be manipulated, classed as cured, leaving others then with real organic diseases to expect the same help that will not be forthcoming and delay the early assistance that medicine could render. The number of patients with psychoneuroses and the number of patients with organic diseases combined with psychoneurotic symptoms must be a large percentage of those entering a doctor's office. Hence, if our work is to be successful we must grapple with this problem more intelligently.

In the first place, I wish to state my complete agreement with the conclusions of the author that a study must be made of the individual personality, the emotional reactions and the factors in the patient's environment as well as a study of the physical status of the patient. I am glad of the courageous manner in which he asks the diagnostician not to tell the psychoneurotic patient that "there is nothing the matter with you." The statement in one case coming to my knowledge led to a pathological depression with an evolution as follows: The patient reasoned: "I have certain feelings and symptoms which incapacitate me and make my life miserable. The best doctor in town, after searching tests with elaborate apparatus of the most modern type, finds no disease. Hence, my sickness is unique and beyond the pale of present-day methods of medical science. Hence, I am indeed hopeless and beyond the power of human aid." This state of depression is often the result of the habit of thought of the physician leading him to deal only in physical manifestations, concluding that no further investigations can be made after a thorough physical examination.

It would be a sad mistake to belittle the physical survey and the wonderful assistance that refinements in diagnosis has brought to us, as it is the rock upon which medicine rests. The essayist very aptly points out the lack of logic in concluding that a certain train of symptoms is always due to deviation from the normal found in the body. The neurasthenic patient has a group of subjective symptoms and at the same time may have certain pathological changes in the body without there being any real connection. The skill in diagnosis that we must display is not the finding of things, but in placing the proper significance on them in the individual case. In a searching survey of a hundred persons, for example, probably not more than a small fraction would be without some demonstrable abnormality. There might be slight anemia, change in the character of the blood-cells, disturbances of the gastrointestinal tract such as constipation or enteroptosis, pelvic disorders in malpositions of the uterus, without any of them having any direct bearing upon the group of subjective symptoms which brings the patient to us. We consider ourselves lucky if we find some definite pathology in the body which is impairing the health of the person to such an extent that nervous fatigue is likely to ensue because such a finding can be attacked directly.

We discredit ourselves, however, if we follow the path of least resistance and fix upon any abnormality that may be present for the indication of our treatment, instituting thereby some formidable procedure like a surgical operation, the extraction of teeth, etc., or refined therapeutical measures which, after completion, leave us with as miserable a patient as we had before, and, in some cases, with the symptoms very much accentuated. As it appears

to me, we must think of the receptivity of the sensorium in every human being in our estimation of subjective symptoms. The receptivity may be increased or diminished by certain physical states, and certainly by the inherent temperament, the personality, and in short, the thing which is called by the writer the "individuality." Also, this receptivity may be influenced materially from time to time by environmental factors which make it necessary that studies be made of them in each individual patient. In other words, a disease such as a psychoneurosis may consist of ordinary somatic impressions of everyday life activity, such as fatigue, sensations from the digestive tract, etc., thrusting themselves upon the mind of the person with such vividness that attention is given to them by consciousness, whereas ordinarily they would be ignored.

It is undoubtedly true that even in real organic diseases we have a psychogenic phase which must be considered, as no two human minds react in the same way to the same amount of somatic pathology. In other words, the lesion in an organ in some individuals does not create a train of symptoms that in another type of mentality would be registering in consciousness frequently. In the consideration of the psychoneuroses we must also consider psychogenic symptoms interlaced with those produced by the histopathology.

THE ADULT EQUIVALENT OF THE FROELICH SYNDROME

By GEORGE KNAPP ABBOTT, M. D.

Adiposity with scanty menstruation or amenorrhoea are common in gynecologic practice. Many such patients show no other evidence of illness, and in the absence of gross pathology of the female organs little has been accomplished in their alleviation. Certain patients with scanty or absent menstruation with nervousness may be benefited by the use of extract of whole ovary or corpus luteum. Others with a distinct thyroid factor may obtain relief from thyroid feeding with or without ovarian extracts. Endocrine dysfunctions affecting menstruation are various and varied. If each such disorder could be reduced to a definite syndrome with specific endocrine therapy, these problems would be easy of solution by careful history-taking and thorough examinations. In the present state of our knowledge such is not now entirely possible. However, any contribution may be welcomed which tends to separate from the mass of such disorders a few cases of apparently common origin with common symptoms and definite results of endocrine therapy. Such is the endeavor of this study. Five patients with an apparently common etiologic factor and similar symptomatology have been selected.

These cases appear to the writer to be a nearly complete adult counterpart of the juvenile disorder known as the Froelich syndrome. The outstanding features are adiposity, scanty menstruation or amenorrhoea, with headache and lassitude. With but little exception, this symptom group is present with all the five patients. The onset in all cases followed closely upon an attack of influenza or measles. In the course of a few months all showed a rapid and remarkable gain in weight ending in a definite adiposity. Lassitude is marked in all, amounting in some of the patients to almost total inability to maintain physical effort for even an hour or two. Exhaustion occurs after both ner-

vous and muscular effort. Headache is present in four, and severe in three. This is constant or nearly so, worse at menstrual dates, and often so severe as to be designated unendurable. It may be bitemporal, frontal, or occipital, and sometimes is located at the top of the head. The onset in one patient was during puberty, and so this one shows a little of the juvenile type, though not markedly so. Three of the five patients showed practically identical symptomatology, and these three obtain definite relief under pituitary feeding.

EXAMINATION

In addition to the usual procedures of a detailed history and physical examination in all cases, special attention was paid to symptoms and findings reputed to be of endocrine origin. Sugar tolerance was high in all, basal metabolism within normal limits, and X-ray of the sella turcica indicated no alteration in size or contour. Special inquiry was made into the matter of focal infections because these are notably common sequels of such acute infections as influenza. Though benefit followed the removal of such foci, yet the main symptoms were but slightly affected.

The symptom group, characteristic of this type of hypopituitarism, is sufficiently well illustrated by a synopsis of case record of patient No. 5, so that we may avoid the tedium of reciting all in detail.

A TYPICAL CASE

Case No. 5 (9817 St. Helena Sanitarium and Hospital, April 15, 1921). A widow, age 23. Has one child age 2. The presenting symptoms are amenorrhoea, adiposity, and nearly constant headaches, with periodic exacerbations at menstrual dates. The family history is negative. The past history shows attacks of measles, scarlet fever and mumps, with frequent tonsillitis. Tonsillectomy was done in 1914, and appendectomy in 1917. An attack of influenza occurred in 1919. The menses have been regular, except the past one and one-half years she has had but five or six periods. The present illness began six months after influenza, when she missed the next five consecutive periods and has missed many since then; others have been scanty. The gain in weight began at the same time, twenty pounds in the first three months, then fifteen in the next year. Much of the adiposity is about the hips. Headaches began four months ago and are frontal and at vertex, and much worse at menstrual dates. They have continued more than half the time for the last three weeks. She is free in the morning; they begin at noon and cease only with sleep.

Examination showed large remnants of both tonsils. Other items were largely negative or normal, except as to adiposity. A diagnosis of hypopituitarism was made and the patient given a dry extract of whole pituitary, 1 grain reinforced with anterior pituitary 1 grain, and whole ovary 2 grains, each three times a day. April 21, 1921, a secondary complete tonsillectomy was done. As shown by the subsequent course, the headaches, which were relieved by the pituitary feeding, returned if it was omitted for two to four weeks consecutively.

May 7, 1923, the patient writes that the first three months of a recent pregnancy (second marriage) she was forced to take pituitary extract for two or three days at a time, and then could go about two weeks before another headache. No headaches occurred the last six months of pregnancy, and no pituitary extract was taken during this time, and none for six or seven months following confinement. At this time the headaches began again and she was advised to use ovarian extract, but with indifferent results. She returned to the use of pituitary extract, which she takes for a few days, and can then go two weeks without headaches, which are otherwise worse at her periods.

The other patients showed a very marked lassitude with the occurrence of the headaches. In two they were constant or nearly so, with no diurnal variation in severity. One patient gained forty pounds in five months, with a total gain of sixty pounds since the onset, which began six months after an attack of influenza. This patient was nearly free from headache, but would easily sleep fifteen hours out of the twenty-four, and was irritable and melancholy. In another patient the amenorrhoea and gain in weight were such as to simulate pregnancy. Experience showed little or no benefit to be derived from ovarian extracts in any of these patients. This was in sharp contrast with the results of corpus luteum therapy in that type of periodic headache previously described by the writer. In one patient the headache and lassitude were so severe that 2 grains of pituitary extract had to be taken four times a day to give relief. Little, if any, change in any of the five patients was observed in either the obesity or amenorrhoea, even when corpus luteum or whole ovary were added.

CONCLUSIONS

1. There is a type of hypopituitarism in adults of subacute onset which in many respects resembles the juvenile Froelich syndrome.
2. It appears to be caused by such acute infections as influenza and measles.
3. Its symptom complex is the rapid production of adiposity with scanty menstruation or amenorrhoea, headaches, and marked lassitude.
4. The headaches and lassitude are relieved by feeding whole pituitary, which must be repeated at intervals. These symptoms are uninfluenced by ovarian extracts.
5. The adiposity and amenorrhoea are but slightly, if at all, influenced by the pituitary feeding. The same lack of effect follows the use of ovarian extracts.

Abstract from Report of Industrial Accident Commission—According to the Industrial Accident Commission, out of approximately one million workmen employed during 1921 there occurred 62,273 injuries causing disability lasting longer than one day and 550 industrial deaths, representing 6,829,294 total days of work lost. It also meant the payment of compensation in the sum of \$3,924,582. In 1922 the reported injuries mounted to 83,246 and the deaths to 700. The figures for 1923 are not yet available, but undoubtedly will show a proportionate increase.

ADENOMATA OF THE THYROID GLAND*

By EDWIN H. SCHNEIDER, M. D., Los Angeles

There are three kinds of goiter, adolescent or colloid goiter, adenoma and exophthalmic goiter.

My reason for choosing adenomata of the thyroid gland as the subject of my paper is because this is the most prevalent form of goiter seen by the physician, because its etiology is probably least understood and because every physician does not always recognize the general pathology of this type of goiter. True adenomata of the thyroid gland are benign tumors recognized as palpable, spherical, circumscribed masses, occurring either single or multiple. The average age at which they make their appearance is at the twenty-third year. From the adolescent or colloid and exophthalmic goiters it is readily recognized by the fact that the enlargement is always asymmetrical and nodular. Histologically, adenomata are readily divided into two classes, encapsulated fetal adenoma and encapsulated adult adenoma. This division is made according to whether the tissue takes the structure of the fetal thyroid or the adult thyroid. Adenomata of the adult form are by far the more frequent. A non-degenerated adenoma upon section shows a homogenous structure and may take on all the changes which have been noted in the thyroid tissue outside the encapsulated tumor. Granular, hyaline, fibrous, cystic, hemorrhagic, calcareous and necrotic degeneration occur within these tumors early and frequently. Malignancy is present in about 1.6 per cent.

Virchow and Wölfler were unable to decide what enlargements were to be considered as tumors and what are merely diffuse overgrowths of physiologically adult tissue. Billroth, Virchow, and Wölfler believe that adenomata arise from embryonic cell rests, i. e., the Cohnheim theory. David Marine, in regard to the etiology of adenomata says: "Cohnheim's conception offers the best explanation of the origin of these tumors when one enlarges it to include the different physiological ages of the development of the main thyroid mass, and that the stimulus for tumor growth is the same as for that of the thyroid as a whole." L. P. Wilson says: "While it may be true that adult adenomata do develop from fetal rests, there is insufficient evidence to demonstrate this beyond peradventure." Adenomata, according to Marine, occur only in thyroids which show a general hypertrophy or hyperplasia.

What is the stimulus which produces an overgrowth of the thyroid gland as a whole and directly or indirectly produces adenomata? A few decades ago great stress was laid upon the influence of altitude and inorganic matter, particularly calcium in the water supply, in the production of goiter. More recent experiments and more careful observations tend to show that adenomatous goiter can be produced by many different agents, inorganic and organic, acting as poisons. Marine, in a recent publication, speaking of adolescent goiter,

says: "We at present must fall back on the view that thyroid hyperplasia is a compensatory reaction arising in the course of a metabolic disturbance and immediately depending on a relative or an absolute deficiency of iodine." A most common factor which increases the need of iodine is an infection. Organic matter is increasingly asserting itself as an important cause, and it is this agent that I wish principally to discuss as one of the etiological factors in adenomata of the thyroid gland. Wilms, in 1910, showed that the residuum of filtered water derived from goitrous districts when added to the usual and harmless water and administered to dogs, guinea pigs, and monkeys produced goiter in these animals. In India during the rainy season, when organic matter is rapidly disseminated, the number of goiters among the whites and natives is greatly increased.

Switzerland, which stands first in its proportion of goiterous individuals, uses human feces in their natural state as fertilizer. Kocher has repeatedly urged the importance of this causal agent in the production of goiter. Suzuki produced enlargement of the thyroid gland in rats by feeding them with cooked rice mixed with rat feces, and also by injecting the latter subcutaneously. McCarrison observed a similar result in animals allowed to drink only water polluted with feces. Marine produced goiter in brook trout placed in polluted water. A great many more experiments could be quoted to prove the relation of organic matter to goiter, but, while the ingestion of organic matter may bring into activity a large number of pathogenic agents, Jaboulay, Klebs, Kocher, Lustig, McCarrison, Riviere, Waters and others have laid stress on some pathogenic organism or its toxin as an exciting cause of goiter. Hirsch's conclusion, as regards the etiology of endemic goiter in his "Handbook of Geographical Historical Pathology," says: "The absence of results to all these inquiries about the genesis of goiter and cretinism—inquiries which have extended to every influence perceptible to the senses that could be brought into the consideration of the question before us—warrants the conclusion that in these diseases we have to do with a specific agent, a veritable morbid poison, and that endemic goiter and cretinism have to be reckoned among the infectious diseases."

Adami thinks that if micro-organisms cause the malady they do so indirectly by forming injurious products in the water; thus goiter would be the result of an intoxication instead of an infection.

Edward C. Rosenow found a streptococcus in goiter removed at operation. Cultivating the streptococcus and injecting it into the median vein in the ear of rabbits, he has produced hemorrhages and lesions in the thyroid gland of these animals. He says: "Strains of streptococci from rheumatic fever, myositis and cholecystitis produce hemorrhages in the thyroid gland commonly, while those from other sources rarely do so." Bloodgood says: "The histological picture of chronic thyroiditis is usually found in the compressed thyroid tissue in the capsule and outside the capsule of the adenoma. As the histological structure of non-degenerated adenomata resembles in structure the surrounding

* Presented to the Section on Surgery at the Fifty-second Annual Session of the California Medical Association, San Francisco, June, 1923.

extra capsular tissue, we must determine why certain portions of the hypertrophic or hyperplastic tissue become encapsulated and undergo early degeneration. We know that adenomata occur in thyroid glands which show a general hypertrophy and that the stimulus for tumor growth is probably the same as that for the thyroid as a whole.

From a consideration of the above experimental facts, it would seem that one or more bacterium or its toxin is the causative factor in most cases of goiter. In 1887, Gregory stated that nature has three ways in protecting the organism against noxious agents: First by ingestion; second by encapsulation; and third by extrusion. That the second method of protection, that of encapsulation of a focus of pyogenic organisms or their toxins, may be the cause of the formation of adenomata seems very reasonable and is further strengthened by the fact that hemorrhagic, fibrous, cystic and calcareous degeneration occur so readily within these tumors. An infection elsewhere in the body may directly or indirectly, by producing a deficiency of iodine, stimulate the thyroid gland as a whole and produce an adolescent, colloid or exophthalmic goiter. Adenoma is a local, circumscribed, a walled-off tumor, a disease of part of the thyroid gland. We could, therefore, expect to find the causative factor locally—that is, within the tumor itself. That pathogenic bacteria are not more frequently isolated from these tumors is not surprising when we remember the usual chronicity of this condition, the generous blood supply of the thyroid gland and the natural antitoxic properties of the thyroid secretion.

In the examination of over 3000 patients with adenomata, I find that over 80 per cent give definite histories of a previous acute infection. It is not unusual to hear a patient say, "I noticed a small lump in my throat a few weeks after a severe sore throat." Examination of these patients often reveals chronic appendicitis, chronic tonsillitis, blind root abscesses, pyorrhea, sinusitis, chronic otitis media, chronic arthritis, chronic bronchitis, chronic constipation, chronic cholecystitis, and pulmonary tuberculosis. The symptoms produced by adenomata depend upon the size and location of the tumor or tumors and the degree of hyperthyroidism. A small adenoma lying against the trachea may produce great dyspnea. This occurs rather frequently in single adenoma arising from one of the lower poles of the thyroid gland. Again, the tumor mass may be the size of one's fist and yet produce little or no discomfort. Pressure symptoms are far more likely to occur in adenomatous goiter than in the other forms because of their tendency, in addition to their general growth, to project nodules which directly or indirectly produce compression of some neighboring structure as the trachea, oesophagus, blood vessels, and nerves.

According to Matthews, paralysis or paresis of one vocal chord is present in 17 per cent of goiters coming for operation. About 25 per cent of adenomata sooner or later, on an average after fourteen years, develop symptoms of hyperthyroidism. In the early stages of hyperthyroidism the symptoms are like those seen in any toxemia; that is, malaise,

lack of endurance, loss of strength, nervous instability, loss of weight, free perspiration, rapid pulse, and a tendency to hypertension. In more advance cases the heart becomes the chief organ affected. Thirty per cent of adenomatous goiter have an enlargement of the heart over one-half inch. The ultimate damage to the heart, liver, kidneys, and nervous system may be just as great as that occurring in acute hyperthyroidism, due to exophthalmic goiter. Why it takes an adenoma about fourteen years to produce symptoms of hyperthyroidism we do not know, but these are the facts, and only by heeding them can we avoid the deleterious effects of this insidious and dangerous disease. Symptoms of myxedema may supervene when the surrounding thyroid tissue has been destroyed by pressure atrophy or by the useless use of the X-ray for treatment.

TREATMENT

A spontaneous disappearance of an adenoma rarely, if ever, occurs. They are, as a rule, but slightly responsive to medical treatment. I believe one is justified in treating medically for a few months a small adenoma of recent origin, but it is absurd and even harmful to treat medically an adenoma of long standing, with pressure symptoms, or with symptoms of hyperthyroidism. Kocher has shown that goiter patients having prolonged iodine treatment show hyperthyroidism earlier than cases not treated at all. Enucleation is the method of choice, since these tumors can now be removed so safely that death from operation is merely accidental. Of course, cases with marked myocarditis have the same risk as any other major operation would have in the presence of this condition. If our infectious or toxic theory as to the origin of adenomata is correct, and most modern evidence points that way, treatment should consist in the removal of all foci of infection both primary and secondary. I believe the mere enucleation of adenomata is not sufficient to produce a cure, and before or after operation a careful search must be made for the etiological agent and it also removed.

Charles C. Chapman Building.

DISCUSSION

Frank H. Paterson (Twohy Building, San Jose)—The presentation of this paper is timely, for the reason that, despite recent advances in our diagnostic methods, goiters of the adenomatous type remain all too frequently unrecognized until severe grades of pathologic physiology have developed. Because these adenomatous or so-called "toxic goiters" represent such varying stages and degrees of partial hyperthyroidism, their diagnosis requires the greatest skill and judgment. The hyperthyroidism of adenoma does not develop until fifteen to twenty years after its appearance and usually persists for a period of several years before the surgeon is consulted. It is in these cases that heart and kidney damage are frequently as extensive as in the exophthalmic types of goiter, and the surgeon is, therefore, more concerned with the ability of the heart and kidneys to functionate than with the contingency of post-operative hyperthyroidism. It is important to differentiate between Graves' syndrome and toxic adenoma of the thyroid—in the former X-ray therapy appears to exert a beneficial influence, at least recourse thereto seems justifiable prior to operation, while in the strictly adenomatous forms, where the cause lies within the thyroid, surgical removal can be depended on to effect a cure.

In adenoma after the thyroid rests become active, the average metabolic rate is plus 35 per cent, whereas in exophthalmic goiter the average runs over plus 50 per cent. While it is conceded that the greatest service we can render, in this, as well as most other ills, is along such lines of prevention as have been made possible through the researches of Marine and others, the surgeon will be, for some time to come, confronted with the problems presented in the advanced conditions until both the profession and the laity are more generally acquainted with the advantages of prophylaxis.

Albert H. Rowe (119 Thirteenth Street, Oakland, Cal.)—Why adenomata of the thyroid which contain fairly normal acinar tissue and which produce thyroxin apparently normal in activity arise in the thyroid is a problem. The iodine deficiency theory of the origin of colloid and adenomatous goiters, to my mind, is sufficient to explain the origin of goiters without taking into account the infection hypothesis which Schneider favors. However, much evidence, as outlined in his article, necessitates the consideration of the latter possibility. Toxic adenomas of the thyroid are insidious in onset, and usually are overlooked except by the specialist who is actively engaged in thyroid diagnosis. Even large adenomas may be held down within the thyroid parenchyma, making them difficult to see and even to palpate. Even minute adenomas may produce hyperthyroidism, and it has been my experience that any thyroid which is definitely palpable and which is firm and slightly irregular and lacking at all in symmetry may contain adenomata. Patients with such thyroids, who have a pulse rate above 85, and a history of even slight increase in nervousness or loss of weight and an increase in subjective body heat, should routinely have a careful metabolic rate determination. In these cases where the average rate is not apt to be over 20 or 30 per cent, the technic of the metabolic rate test should be carefully performed and the result checked up by a clinician who is constantly in touch with pathological thyroid material. We frequently see patients who have received incorrect thyroid diagnosis based purely on metabolic rate determinations which have not been skillfully performed. All toxic adenomata require surgical treatment, and the results obtained are often magical. When the adenomata are encapsulated, enucleation is sufficient. However, a different adenomatosis of the entire thyroid gland is not uncommon, which condition requires the subtotal thyroidectomy which is now done by all surgeons for hyperplastic goiter. Post-operatively, the clinical condition of the patient should be followed with the help of metabolic rate determinations, in order to ascertain that the hyperthyroidism has been properly controlled or that a hypothyroid state does not occur as a result of the surgery. In my opinion it is wise to enucleate adenomata, which are not toxic, since they can be easily removed with local anesthesia, and this before any toxic damage to vital organs has occurred.

H. H. Searls (University of California Medical School, San Francisco)—The classification suggested by Schneider is the one commonly used today, except that a distinction is usually made between the adolescent, or simple hypertrophy, and the colloid goiter. Pathologically, simple hypertrophy gives us a microscopic picture within normal limits, while the colloid shows markedly distended alveoli packed with heavily staining colloid and lined by flattened epithelium. The well-developed colloid goiter shows such a different picture under the microscope from that of the typical adolescent, that a separation of these two types in the classification is warranted.

There does not appear to be sufficient evidence to credit the development of adenomata to an infectious factor when it has the pathological characteristics of a true benign encapsulated tumor of thyroid tissue. Should this hypothesis be accepted, then a similar etiology would have to be considered in similar tumors of other tissues of the body.

Schneider states that examination of 3000 patients with adenomata showed 80 per cent with history of a previous acute infection. Could not a similar history be obtained in 3000 cases of fibroid of the uterus, for instance, or breast tumors either benign or malignant?

The harmful results of the X-ray treatment of adenoma of the thyroid cannot be too strongly emphasized. There is very positive evidence that it does not have any action on adenomas, and merely injures the surrounding thyroid tissue. Frequently, particularly in the larger adenomatous goiters, the surrounding glandular tissue has been severely injured by the pressure of the contained adenomas, and in such instances the added insult of X-ray therapy results in the development of myxedema.

THE EFFECTS OF POSTURE ON RELAXATION UNDER ANESTHESIA

By CAROLINE B. PALMER, M. D., San Francisco

The importance of posture under anesthesia is commonly acknowledged as having a bearing upon respiration, circulation, strain on muscles and joints, and pressure on nerves. Less commonly the effect upon relaxation and the required depth of anesthesia for surgical operations is considered, but in every-day practice the subject is disregarded to an astonishing degree.

Surgeons ordinarily, when making an examination for a suspected pathological condition of the abdomen, for example, place the patient in a posture which gives the greatest possible degree of abdominal relaxation, but the actual operation is frequently performed upon a patient in such a posture that the abdominal muscles are on a considerable tension. This naturally necessitates a much more profound degree of anesthesia, and is sometimes the determining factor in the use of a toxic anesthetic such as ether, instead of a non-toxic anesthetic such as nitrous oxid and oxygen.

(1) The ordinary dorsal position on a perfectly flat surface, often with a very thin inadequate pad between the patient and the table, is one of considerable strain. This is greatly increased in the case of muscular or fleshy patients. (2) Simply using a pillow of the proper size to bring the head in line with the body adds greatly to the patient's comfort by relaxing the neck muscles. It is not sufficient to use the same size pillow for all patients, for naturally one that would be satisfactory for a slender patient, such as the one shown in the slide, would be entirely inadequate for a larger patient. This seems almost absurdly simple, but I venture to say that not all hospitals provide pillows of various sizes for their operating-tables. (3) Flexing the thighs to a greater or less extent adds greatly to the patient's comfort, and by easing the tension on the abdomen increases relaxation. Frequently when this is done, patients say, "Oh, that's better." The use of a small firm pillow under the back decreases the probability of post-operative backache, but here again, it is necessary to have pillows of various sizes. Too large a pillow increases tension. It is a safe rule that, unless the back pillow is comfortable while the patient is awake, it is not of the correct size or is not properly placed.

(4) To further increase abdominal relaxation,

it is sometimes of advantage to elevate the thorax to some extent. In the picture I purposely accomplished this by means of pillows as suggesting that an especially constructed table is not required.

(5) The ordinary Trendelenburg position is one of considerable strain, and certainly in this posture the abdominal muscles are on a definite tension. When we were taking the picture for this slide, the model remarked that the posture was decidedly uncomfortable, but as soon as we flexed the thighs and supported the legs (6), she volunteered the information that the posture was comfortable. The simple experiment of raising and lowering the legs shows definitely the relaxation of abdominal muscles with the legs raised and supported as in this illustration, and the tension of the same muscles when the legs are lowered (7). The use of the back pillow in this pernicious type of Trendelenburg position may decrease post-operative backache, but certainly does not add to abdominal relaxation.

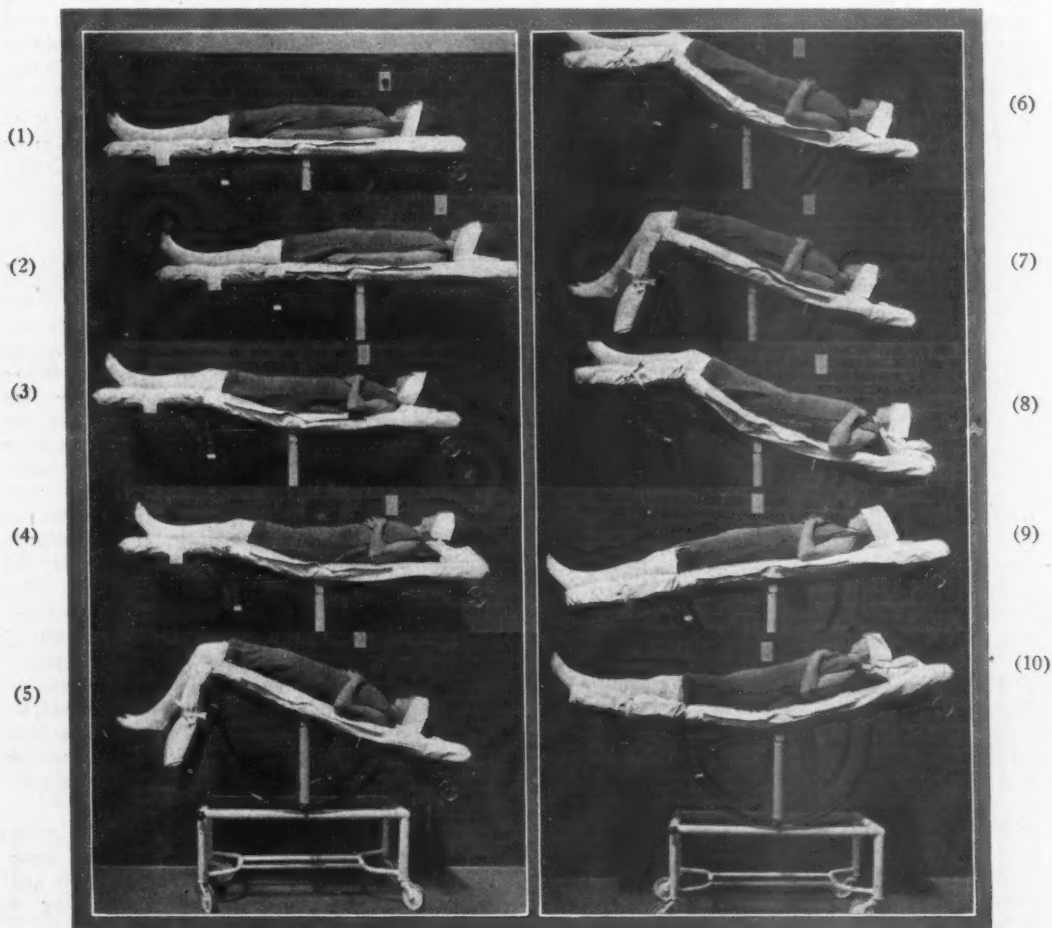
(8) Raising the thorax in what I venture to call the correct Trendelenburg position sometimes assists in abdominal relaxation just as it does in what I venture to call the correct dorsal position (4 again). (9) The reversed Trendelenburg position

causes a degree of strain which actually interferes to some extent with respiration.

(10) By flexing the thighs, raising and supporting the legs, and slightly raising the thorax in addition to the inclination of the table, the entire anesthetic condition is changed for the better, and there is a definite increase in relaxation.

I sent this series of pictures to D. A. Sargent of The Sargent School for Physical Education, Cambridge, Mass., and asked his opinion as to the effect of the changes of posture here shown. I quote a portion of his reply: "What you accomplish by the suggested change of position seems to be the relaxation of the flexors of the femur and those of the trunk and the neck, which of course relieves more or less the tension on the abdominal wall."

At Stanford University Hospital, as a result of observation in a series of more than 10,000 cases, we have come to believe that due attention to posture during induction and maintenance of anesthesia pays large dividends in ease and rapidity of induction of anesthesia; greater relaxation; less profound degree of anesthesia required; better condition of patients after operation; and greatly decreased post-operative discomfort.



EDITORIALS

1924 STATE MEETING

All members who desire to read papers at the State meeting should communicate immediately with the secretaries of their sections. Each section holds but three meetings and, in consequence, has time for a very limited number of papers.

A few secretaries have already sent in their programs. Will all members who have papers to submit send the title and abstract of their papers to their section secretaries at once, and the completed manuscript not later than February 15? After that date, papers are no longer acceptable for the 1924 meeting.

PAINLESS INTRAMUSCULAR INJECTION OF NEOARSPHENAMINE

The chief objection to the use of neoarsphenamine by intramuscular injection has been the local inflammatory reaction resulting in considerable pain. If neoarsphenamine, and similar products, could be administered intramuscularly without the local reactions, it would be a distinct step forward in the therapy of syphilis. It would practically abolish the dangers attendant upon intravenous injections, and permit easy and safe administration in children in whom intravenous injections are sometimes technically difficult, if not impossible.

The problem of rendering intramuscular injections of neoarsphenamine painless and without local inflammatory reaction has been recently studied by Freud of the Pharmacological Institute in Vienna, with distinctly promising results. In dogs, Freud found that the intramuscular injection of 0.15 gm. of neoarsphenamine in 5 per cent alypin nitrate containing 5 to 10 per cent acacia produced only a slight rubefaction at the site of injection, while the same dosage of neoarsphenamine injected alone caused marked infiltration of the tissues and rubefaction. Out of ninety-one adult patients injected intramuscularly with 0.15 to 0.45 gm. neoarsphenamine in 7.5 per cent acacia containing 5 per cent alypin, only six, or 16 per cent, showed rubefaction, while 30 per cent of patients injected with 0.05 to 0.15 gm. neoarsphenamine without acacia and alypin showed local reactions. So far as the colloid (acacia) was concerned, the best results were obtained with 7.5 per cent acacia. Good absorption of neoarsphenamine was preserved and pain was reduced. Ten per cent acacia retarded the absorption too much. The role of the alypin in Freud's mixture is simple and quite evident, but that of the acacia is more complex. According to Freud, the acacia serves two objects: firstly, it supports the action of the local anesthetic, and, secondly, it protects the neoarsphenamine against the decomposing and precipitating influences of the added local anesthetic (alypin). Thus, it seems that Freud's mixture is not a case of empirical polypharmacy, for it rests on the application of scientific principles derived from the physical chemistry and pharmacology in the improvement of

therapy. From the practical standpoint, and most important of all, is the claim that the clinical results from the intramuscular administration of neoarsphenamine in the acacia-alypin mixture are at least as good as from intravenous administration, and free from the dangers of the latter.

Freud, P.: Arch. f. exp. Path. Pharm. 1923, 97:54. "Über Verhinderung der entzündlichen Reaktion nach intramuskulärer Neosalvarsan-Einspritzung."

WHY NOT SOLVE SOME REAL PROBLEMS?

The most important known essentials to prevention of disease and the prolongation of life are neither numerous nor hard to understand. Most of our modern literature deals with matters that would be of more or less minor importance if we would only correct a few of our fundamental failings, for the most part quite generally ignored.

The interesting article by Anna Rude on the Midwife Problem (Journal A. M. A., November 12, 1923) calls attention to one of the murderous customs of the dark ages that is still prevalent. If it is true—as it undoubtedly is—that obstetrics, including prenatal care, delivery of the child, and after-care of both mother and child, constitutes the practice of medicine, why should there be a midwife problem? Why should there be midwives or any other classes of inadequately educated or, more often, ignorant people carrying on this exacting specialty of medicine—with or without the sanction of the law?

Rude tells us what we suspect is only part of the story, that there are over 40,000 midwives or what not practicing obstetrics in the United States. In other words, there are one-third as many incompetents practicing in a difficult field of medicine as there are physicians.

The end-results of this situation can only be guessed at, but certainly they are not creditable.

CALIFORNIA'S SITUATION

According to Rude, there are 104 midwives authorized to practice in the state who attend 8 per cent of maternity cases. Although the author does not estimate that any unauthorized persons are practicing, it is a matter of common knowledge that there are many of this class, and that when necessary certain persons will sign the birth certificates for them, just as certain persons authorized to practice do sign death certificates for patients whom they never saw and who were attended by unlicensed practitioners.

There is no excuse for inadequately educated persons practicing obstetrics or any other branch of medicine in California, because we have one physician to each 500 of population, and they are so well distributed that, in practically all instances, good services may always be obtained. This is particularly true for a condition that requires service at a rather definite date well known in advance by the patient and the doctor.

What is needed in California, and to a much greater extent in some other states, is for some powerful organization to attack and solve this and other major health problems instead of trying to surround them with alleged safeguards.

SELLING "ELIXIRS OF LIFE"

A considerable portion of the Edwin Smith Papyrus written in the seventeenth century before Christ is devoted to discussion of

"The incantation for transforming an old man into a youth of twenty."

The subject was not new then, but can be traced back through further centuries until, like other historical data, it becomes lost in the mazes of mythology and antiquity. During nearly 4000 years since the early written accounts, there are numerous and more or less connected references in the literature of efforts and methods of restoring sexual youth to the aged. At almost every stage of world development are records of alleged discovery of the true elixir of life and its sale to the public by ubiquitous Ponce de Leons. Many of the vendors profited greatly by these sales, just as they are profiting now by promoting one or another of the numerous and "only sex restorers" offered for sale to a gullible public.

Amulets are still sold as in the days of Babylon. The "Fountain of Youth" wells of Egypt and of the Irish folk tales are always in the land of Bimini just around the corner. Sorcerers still bend over blue flickering braziers and vamp youth back into the aged as they did in the days of Hermippus.

The youth-restoring milk from the blended male and female goats of antiquity has been replaced by an easier but no more certain use of the goats' sexual organs.

Aged flappers, male and female, with the sagging tissues of their necks "hooked up" by surgeons, and their exposed wrinkles ironed out by massage until they look like billikens, insure plenty of propaganda that is utilizable as "news." As "exhibits," they apparently bask in the notoriety they gain from the pathetic exposition of their pictures and senile statements to the public. Their careers are usually short, because the old arteries go on hardening; the creaking joints continue to stiffen, and the brain continues to soften all the more rapidly because they are unnaturally speeded up and not allowed to grow old gracefully.

This remarkable opportunity, of publicity ready-made and a mad world trying to defeat God's edict, proves too much for some physicians who themselves fall for the glitter of gold and the tinsel of notoriety. This is the most sickening phase of the whole situation. The attitude and conduct of some physicians in California and elsewhere is casting reflection upon other members of a creditable profession and is causing many people who look to physicians for guidance, to jeopardize their health and squander their funds for a new youth that is no more attainable by the use of monkey glands, goat glands, or what not, than it was for those other silly fools who followed the incantations of the Nile doctors.

Two European "doctors," Steinach and Voronoff, now appear to be jockeying for first place in advance propaganda preparatory to making a fortune out of the health and lives of our citizens. One of them appears to be waiting for his much-advertised monkey farm in Africa to become suffi-

ciently populated with the strong healthy males of the species, while the other is to be accompanied by his own surgeon who will perform the "difficult," "new" operation that is old and is performed several hundred times a month in our country, to prevent propagation of the unfit.

In the meantime and while awaiting the arrival of these elderly "leaders" who apparently have not healed themselves, we are being entertained by the vulgarities of "little Voronoffs" from the ranks of our local profession. Their "press agents" are making them notorious; their disgusting, nauseating practices are damaging the standing of a humanitarian profession, and many silly, often senile, citizens, rich and poor, are being duped by alleged remedies for sexual impotence.

Our medical societies expel members who follow other cults, and they ought to expel advertising alleged "gland specialists." This not only for the honor of their profession, but for the cause of better medicine for all citizens.

Nothing in this editorial is intended to reflect upon the splendid research work going on in many places but which is not put forth prematurely by propagandizing specialists for their own aggrandizement and to the detriment of the public in health.

ECONOMIZING IN STATE "HOSPITALS"

According to news dispatches from Sacramento, as a result of the economy program of Governor Richardson, the cost of care of the patients in Napa State Hospital has been reduced from \$21.75 in November, 1922, to \$19.24 in November, 1923.

This information, which apparently is given out as something to be proud of, should be challenged in the name of those who are not able to speak for themselves. Such shamefully inadequate costs can be arrived at only by "special" methods of accounting or by rendering poor service to the sick. Every person who has the responsibility of providing a living knows that neither the 72 cents a day for 1922 nor the 64 cents a day for 1923 are sufficient to provide good housing, clothing, subsistence and other costs for healthy people, much less those who require all of these things and medical, surgical, nursing, laboratory and other forms of care in addition.

In no branch of medicine has greater progress been made than in the treatment and management of neuropsychiatry patients. The splendid results that are being reported from a few Government hospitals elsewhere and many private ones from everywhere are not attained at a cost of a few cents a day. The daily per capita actual cost of the minimum of good institutional, medical, surgical, nursing, X-ray, dietetic, laboratory, and other care of these patients is expressed in dollars instead of a fraction of a dollar. This regardless of the character of management or ownership of the institution rendering the service.

The ultimate cost to taxpayers is not so much greater for efficient care than it is for the custodial care still too prevalent in politically controlled "hospitals." This is because a much higher percentage of the patients become much improved and

many recover and are restored to usefulness when adequate treatment is given. Then, too, some healthy physicians and nurses cannot serve long and maintain their mental poise in some of these so-called hospitals that give such care to patients as is possible at a cost of a few cents a day.

The demands and criticisms of whole-minded patients and their friends in other classes of hospitals exert a powerful influence toward the constant improvement of these hospitals. There is no such chance in hospitals for those whose minds are darkened and where visiting periods are so rigidly controlled. This should make us all the more solicitous for the welfare of the benighted patients. Every known possibility for improvement in the mental and physical condition of each of these patients should be patiently exhausted before they are treated as derelicts.

Efficient "hospital" care of the mentally irresponsible is one thing and the "custodial" care of the hopelessly demented is another and much less expensive service. Both are necessary. No government should have the right to place patients in the "custodial care" class until they have been carefully studied by staffs of competent physicians under real hospital conditions and all hope of their betterment under any circumstances has been given up.

We do not believe that the people of California desire or, if they knew, would tolerate less than we have indicated for their fellow citizens who are unable to speak for themselves. Intelligent persons will very well know that adequate hospital and professional service is not, and cannot be, rendered at a cost of a fraction of a dollar a day.

The facts as to what is being done and what is not being done are matters of record, but until such time as some powerful and active civic organization becomes interested in the question, publication of additional facts would serve no useful constructive purpose.

WHY "POSITIVE HEALTH"?

The double negative has long been subjected to the attacks of grammarians for the very simple reason that its meaning is exactly the opposite of that intended. The double positive is not in such ill-repute because it is seldom used and only Shakespeare, with his "most unkindest cut," is permitted to use the double superlative without censure, if not without comment.

There is a double positive recently come into common usage by certain health workers, however, that ought to be consigned to the graveyard of things-that-never-should-have-been, and that is the phrase "positive health." Surely, disease in itself is negative and, consequently, health must be positive. Why paint the lily?

Some American medical journals are guilty of using this deplorable term, and at the recent International Health Education Conference in San Francisco it was lipiped with great frequency. Of course, it is understood that the phrase is intended to cover generalities, but when we have so many words with which to be specific and so many health subjects that require exactness, why should we

positive the positive so glibly and so meaninglessly?

Health education is vastly more than the imparting of mere generalities. Pupils must receive their education in health by means of simple, direct statement of fact. The teacher who can talk only in vague generalities cannot teach. The public, furthermore, wants and will get its health information in definite terms. Leaders in the advance of the public health movement of today must know exactly the message that they have to give, and they must know how to present it in clear, simple, direct, plain Anglo-Saxon. Heavier pressure on the positive alone will never eliminate the negative, and ostrich-like methods in not recognizing disease will never result in the promotion of the public health.

COLORADO'S "MATERNITY LAW"

Colorado has a new "Maternity Law." It has some interesting features. Provisions are made for the expectant mother during the last six months of her pregnancy. The infant's welfare is assured during its first six months after birth. The operation of the law is in the hands of the Children's Court, over which Judge Ben Lindsay presides. Either the mother or friends may make application for relief, which includes all varieties, from cash to medical and hospital care. All proceedings are conducted in the most confidential manner. Physicians and hospitals and nurses are paid for their services.

Unmarried mothers are given the same confidential care as others, including loss of identity in maternity hospitals. Infants of unmarried mothers will be placed in homes upon request. The law also gives the court wide authority in dealing with the father responsible for an illegitimate child.

It is claimed for this law that it requires no enlargement of government machinery and that its benefits are easily and confidentially available without red tape to any mother unable to pay the necessary costs of adequate assistance.

The power of the court to require fathers to accept financial and other responsibility for their illegal children is expected to reduce the cost of operating this law to the taxpayers.

This all sounds too good to be true.

PERSONAL PUFFERY

No conscientious physician can examine large press-clipping services and read the great number of letters that pour into the office of any medical organization without becoming gravely concerned over the tendencies of so-called "education of the public" in medical subjects. The movement for Medical and Public Health Education for the Public is as old as medicine itself. There are on file in libraries plenty of resolutions and discourses upon it dating back through the centuries. We have recently read some that might be republished today, as new and as appropriate as they were when originally presented centuries ago.

Of course the public should be informed—as far as they are capable of comprehending without medical education—upon all subjects pertaining to

better health. A review of what has been, and what is being, produced along this line indicates rather depressing conclusions. Much is being put out that is inaccurate in this or that particular point, depending upon the source of the alleged information. Many of the subjects discussed and conclusions drawn for the alleged benefit of the public are controversial even among physicians themselves. The result is that, if one collects the press clippings, the "release stuff," the text-books and brochures of all sorts that are being put out upon some phases of the question, he can find just as great a variety of opinions as those already existing in the minds of the public. In other words, we are not clarifying public opinion at all, but actually confounding the confusion that already exists.

On the other hand, some of the educational material, and particularly that which is given out in an impersonal way, is accurate, reliable, well digested, and well presented. It is unfortunate that this class constitutes only a small fraction of the other kind.

In addition to the confusion that is being confounded by the inaccuracies and general character of much of the medical educational literature, we have the lack of sufficient knowledge among the "educators." It, of course, should be obvious that a teacher in the field of public health and medicine, regardless of who is being taught, must first himself have sufficient knowledge of the subject he is teaching to present it clearly and accurately. It probably would not be an overstatement to say that not one out of a hundred of those "informing" the public upon medical and health subjects knows what he or she is talking about. We thus have another explanation as to why the general public is confused about even the simplest subjects of medicine and public health.

This also accounts, to a very remarkable degree, for the prosperity of quackery of one sort or another at the present time—a prosperity never before seen in the history of the world. Our modern medical frauds are no different in their fundamental operation from those of earlier times. Cultists and quacks rely upon the ignorance and superstition of the people they propose to serve. Inaccuracies and confusion in supposedly authentic "educational material" and the lack of education of the instructors themselves, as shown by examination of their sayings, give to quacks chances which they never before had.

Another danger in this situation, which has been pointed out recently by many thoughtful writers, is that the controversial points in public health and medicine, as well as the froth and more or less immaterial points, are receiving the maximum amount of attention, while the essential and major subjects are being neglected or relegated to places of secondary importance. Questions like vaccination against smallpox, inoculation against diphtheria, pure water and air, and food supplies, general sanitary conditions, exterminating disease-bearing insects, and many other fundamental problems, are receiving scant attention; whereas propaganda as to the use of monkey glands, cancer specifics, tuberculosis spe-

cifics, and similar movements, receive tomes of publicity and dogmatic conclusions from ignorant or commercially interested persons.

Finally, the worst feature of all is the personal puffery that is being put out by certain doctors, groups, and clinics for their own aggrandizement and the promotion of persons toward which the propaganda directs the arrow. The great injury of this sort of unethical puffery is being more and more felt by conscientious physicians, and they resent it for themselves and because it detracts from public confidence in the profession as a whole. The editor of this Journal receives many letters from physicians criticizing the conduct of some physicians, clinics and organizations for this type of propaganda, and if the feeling in the hearts of the majority of good physicians were known to some of these personal puffers it might cause them at least to use more subtle means of self-advertisement and self-aggrandizement.

Some of these doctors come out boldly under their own names and often with their photographs, while others hide their heads in a clinic or some other organization and imagine that their real motives will not be understood. Brothers, it takes a great deal more subtlety than some of you are using to fool the general public—much less physicians.

SAN FRANCISCO COUNTY MEDICAL SOCIETY APPROVES ADULT HEALTH CENTER FOR THE UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

The Out-Patient Department of the University of California Medical School and Hospitals has established an "Adult Health Center" for the "periodic examination of apparently normal individuals." This movement, as explained in the following outline of policy, was presented to the board of directors of the San Francisco County Medical Society at its meeting on October 9, and approved by them for the county society:

Adult Health Center, University of California Medical School

The Out-Patient Department of the University of California Hospital is establishing, under the jurisdiction of the Department of Medicine, an Adult Health Center for the periodic examination of apparently normal individuals. The purposes are: (1) To detect early disease processes, faulty hygiene or other conditions which, if not corrected, may result in impaired health; and (2) to educate the medical student in normal variations in health and early symptoms and signs of disease.

The Adult Health Center will examine indigents or those of small means who are unable to pay for the services of a physician. The fee will be \$1, to include an examination of urine, stool, blood, Wassermann, and vaccination for smallpox. Applicants who are found ineligible for the examination by reason of ability to pay, will be referred to their family physician.

The examination offers no special problem, and is one that any physician may undertake in his private office. Emphasis will be placed on corrective measures when defects are noted. Physicians will be welcome.

The Adult Health Center will extend the work which has been going on for years in the Department of Pediatrics and Obstetrics of this and other medical schools, to the adult group in the Department of Medicine. Such work has

embraced the clinics for well babies, children of pre-school and school ages, the prenatal care of mother and child, and care of the mother for at least a year after delivery. These activities will be continued.

Of course, every physician and every physicians' organization is interested and concerned in providing facilities for medical and public health care of all people, of all ages, everywhere. The American Medical Association has approved the policy and provided a plan, including physicians' office records, for the periodic examination of "apparently normal individuals." A number of private organizations, well financed, are in the field to accomplish this purpose through various forms of membership or insurance policies. Hundreds of members of the California Medical Association are now engaged in doing this work for one organization or another, as well as for the members of their own clienteles.

It is illuminating to note the advance among groups, clinics, and municipal health organizations of one sort or another in the development of this field. Some of them limit their work to people who can pay for the service in fees of from \$1 up; others are altruistic enough to offer service only to those who are able to pay \$1 or less.

Two years ago the California Medical Association, through its House of Delegates, passed a resolution making every physician's office in the state a "health center." That resolution, with explanatory comment, was published in the November, 1922, number of the California State Journal of Medicine, and is as follows:

Health Centers

Resolutions adopted by the House of Delegates of the Medical Society of the State of California on May 17, 1922.

Whereas, It always has been and is the primary purpose of physicians to give trained, scientific, sympathetic service to all of their fellow-citizens who need medical advice and to furnish this service to all alike, regardless of the social or financial standing of the patient, and

Whereas, It never has been and is not now necessary to interpose any agency not under the direct supervision and control of competent members of the medical profession between the physician and his patient. Co-operation in agencies where such medical supervision and control does not exist often proves detrimental to the interests of both patients and physician, and

Whereas, In order to re-emphasize these policies and practices to all citizens of California, and to counteract the influences going about the State to the effect that consideration by physicians for those needing medical advice can be obtained only by applying to some non-medical organization, and in order that the public may be fully informed and free to call directly upon the physician of its choice, with the assurance of sympathetic and confidential consideration, therefore, be it

Resolved, By the California Medical Association and representatives of all county and other constituent organizations, in convention assembled, that the office of each of its 4000 members throughout the State is a "health center" of the kind that means the best medicine and public health advice that physicians can give; this upon the basis that those who can pay in full should do so, those who can pay part should

do so, and those who are unable to pay should have the service without cost.

Resolved, That in order to secure special financial consideration, the patient is requested to execute and sign a paper showing his socio-financial status and setting forth briefly the reasons why he must ask for special financial consideration, this being the policy now being followed by honest clinics and welfare organizations.

Physicians' Offices As "Health Centers"

One of the important resolutions passed unanimously by the House of Delegates at the last annual meeting of the State association was printed on the front cover of the November, 1922, Journal. Contained in the minutes of the House of Delegates, as part of that resolution, is the following note:

"The State society will supply each of its members with appropriate blank forms for this purpose, and will furnish one to any citizen who desires to use it. One of these forms presented to any member of the State society in any part of the State will insure the courtesies and special consideration that his condition warrants and, in addition, he will receive the same sympathetic, confidential, constructive help that is given to the person who is able to pay fully for all that he requires. In carrying out this program, physicians reserve the right, when they think wise, to check up on the accuracy of the applicant's statements in an unobtrusive and sympathetic manner, in exactly the same way as those reports are now being checked up by clinics and other welfare organizations. Members also reserve the right to refer applicants for special consideration to other physicians under the same conditions and for the same reasons that they would refer patients paying regular fees. Any sick person in any part of the State of California who fails, for any reason, to secure adequate medical attention is requested to communicate with the secretary of the State Medical Society, 1016 Balboa Building, San Francisco."

It is the general impression among physicians, and the resolution itself so states, that it is a re-emphasis of the practices and policies of physicians everywhere at all times.

There are two outstanding features of this resolution, the most important being that physicians are ready to render service to any person requiring professional care; that those who are able to pay the physicians' regular fees for this service should do so, those who are able to pay part should do so, and those who are unable to pay any of the fee should have the service just the same; all services, regardless of the status of the patient, to be rendered in the same high grade, confidential, sympathetic manner. The other important feature in the resolution is that it never has been, and is not now, necessary to interpose any agency not under the direct supervision and control of competent members of the medical profession between the physician and his patients.

It has been said by some that, if the spirit of this resolution were applied, physicians would not be able to give adequate care to all of the ambulatory sick in this State, particularly in certain congested centers. The facts are, that members of the medical profession now take care of all of the ambulatory sick, as well as those who are bedridden and require more time, and, furthermore, the problem in the aggregate is not as large as some people seem to think. If all the sick people in the State of California, of whatever class, kind and condition, were divided up equally among the seven thousand educated physicians practicing in this State, they would have less than twenty sick people

each to look after. If the ambulatory patients were so divided, the doctors' offices of this State would average less than ten visits per office per day.

The primary consideration in the carrying out of this or any other resolution or policy of the medical profession is, that the sick people, regardless of class of sickness, their place of residence or any other consideration, should have adequate medical care. This medical care should be available to all ambulatory patients in physicians' offices and to all others in their homes, hospitals or wherever else they may be. The resolution of the State Association is an effort to make these facilities available in a practical manner.

If the terms of this resolution were carried out in good faith—as they are being carried out by some members of the State Association—there would be little room or little excuse for more elaborate and pretentious clinics. There is in San Francisco County, for instance, one physician to each 500 of population, which is four times as many as necessary to give the public health advice and treat all the sickness that occurs in the population, provided this work could be allocated. Many of these physicians, members of our society, have very small incomes, and many of them, if they would follow the terms of the resolution of their own State Association, might develop a future clientele and make many friends, by the examination of apparently normal individuals for very small fees.

Careful work has shown that among the population of any community periodic examination shows the necessity of a certain amount of professional work in more than three-fourths of those examined. This periodic examination is a very important service to a community; it ought to be done by physicians in their offices, but if physicians are not willing to do it upon the basis of accepting a fee commensurate with what the person is able to pay, then it is perfectly proper that clinics of state or municipal organization undertake the service and employ physicians to do it.

If it is necessary for clinics to do this work for people who are unable to pay more than \$1 for each service, it is likely that the large volume of medical work which is developed by these clinics will be performed by the hospitals and members of the clinic making the original examinations. This is a most important point and ought to have serious consideration by physicians who have spent large sums of money and made many sacrifices to get an education.

Another point that must not be lost sight of in making periodic examination is that the record of the examination should be available to the physician who is going to treat the patient in any illness that may be discovered by the examination, and also to other physicians who may later be called upon to treat the patient.

Between the efforts of various insurance companies, life extension institutes and similar organizations, groups of physicians and individual physicians who are now and long have been engaged in making periodic examinations, and the crop of "periodic examination clinics" that are sure to develop, the people of San Francisco ought to be well served in their examinations.

COUNTY NEWS

ALAMEDA COUNTY

Fabiola Hospital—New Maternity Building Opened—On December 15 Fabiola Hospital opened its new Maternity building for inspection by the public. A luncheon was given for the staff in the nurses' home, attended by about 160 physicians, including several guests from San Francisco and other nearby points. Throngs of people visited the building from 2 to 5 in the afternoon and were served with tea. Mrs. J. P. H. Dunn, assisted by other members of the board and members of the staff, explained the workings of the new department to the visitors.

The new unit contains 21 private rooms, 29 ward beds, 2 cubicle wards of 5 beds each, 2 two-bed wards, 5 three-bed wards. There are two delivery rooms, two nurseries, one isolation nursery, two doctors' rooms, as well as a complete X-ray and deep therapy treatment department. The cost of the building and equipment was approximately \$260,000. During the last ten years the hospital has done \$113,000 worth of free and part-pay work, there being a daily average of ten free and part-pay patients treated during 1922.

Dr. Liliencrantz, president of the staff, presided at the luncheon, and called upon Daniel C. Crosby for a brief outline of the history of Fabiola Hospital, and Dr. Crosby responded as follows:

In 1876, when Oakland was a small community—scattered over a large area with few of the usual municipal advantages and improvements which characterize many smaller communities of the present day—a man was severely injured upon one of its streets. The injury was a terrible one and the County Hospital, such as it was, was ten miles away, and there was no ambulance and no trained people to transport him. Transportation in a lumber or hay wagon meant death in all probability, and the by-standers stood aghast.

Mrs. R. W. Kirkham, who had recently come to Oakland to make her home, passed that way, shared in the horror and anxiety of the by-standers, and with much surprise learned that Oakland possessed no hospital of any sort. Her comment was short and direct and pregnant with meaning, "Then Oakland must have a hospital."

There were then in this community, as there are always in all communities, people of philanthropic instincts and altruistic vision who were willing to make and lead others to make practical applications of their philanthropy and altruism. Eighteen women, of whom Mrs. A. Liliencrantz, Mrs. I. E. Nicholson and Mrs. Alice Cameron still survive, organized a hospital and dispensary association, and, being closely allied with several enthusiastic homeopathic physicians, called their new venture "The Oakland Homeopathic Hospital and Dispensary Association."

From small beginnings, great enterprises grow—as the oak from the acorn. The acorn of development of Fabiola was a tremendous need, which awoke a fine enthusiasm, and each woman of the original eighteen subscribed \$50 for a life membership. This limited sum of \$900 in money and a limitless wealth of the milk of human kindness constituted the nucleus from which the present institution has evolved.

The declared object of the association was to provide a home for the sick, worthy poor, entirely without means or for those with limited means, but no home. Two free beds were to be maintained, and for such other beds as could be provided, a fee, graduated in proportion to the patient's means, was to be charged for medical attendance and hospital care. The corps of medical attendants were to give their services without fee.

A small house secured at Nineteenth and Market

streets, painted, cleaned and refurnished by the hands of Mrs. H. C. Taft, Mrs. W. W. Standiford and Mrs. Wallace Everson, was turned into a hospital and dispensary, and here the first patient, a homeless, young woman, late in pulmonary tuberculosis, was cared for for six months until her death. Even her burial was attended to by the association. After another protracted case, which terminated fatally, the County Board of Supervisors voted \$40 per month to the association on condition that it care for all cases referred by the board.

After one year of this experiment, the Hospital Association having lost \$100 in the process, this stipulation and agreement was discontinued, and from that time the board of directors have depended upon their own efforts and the community interest which they have been able to develop to maintain their enterprise.

The list of contributions in the early years is very interesting (three quarts of milk for two months; a basket of fruit; two dozen towels; a chicken; ten dollars; and innumerable items of necessities in small amounts) and shows that, while these women were working in a small way, their interest and oneness of purpose was always emphasized. When a child's bed was contributed and a few toys were given to interest the child, there was much glee at the increased facilities.

By 1883 the hospital had outgrown its quarters; a house at 1057 Alice street was purchased and the good work went on. However, after a lapse of three years this place was no longer adequate and new arrangements were necessary. When the inadequacy of the Alice street location became apparent, the need of material change appealed to two men whose names must be inscribed with gratitude whenever the interests of Fabiola Hospital are considered. Anthony Chabot, with a generosity typical of him, presented to the association the two and one-half acres upon which the institution now stands and Frederick Delger contributed \$5000 toward the erection of a building.

Following these two red-letter events in the history of the institution, the annual report of 1887 announces that "we are about to erect a hospital building after the models of the most eminent sanitary engineers." This building was erected in due time and now constitutes the old building of the present group, and is the one which must, within the next few years, be replaced by a fireproof structure.

Up to January, 1887, as many free as pay patients had been cared for in the hospital and this was rendered possible by the very generous support which had been given the institution by a gratefully interested public.

At this time, feeling that the public should know and understand that the institution was not devoted entirely to homeopathic practice of medicine, the name was changed from "The Oakland Homeopathic Hospital and Dispensary Association" to "Fabiola Hospital Association." The name "Fabiola" was chosen because of the noble Roman matron who in the fourth century went about the city of Rome caring for the sick poor and established the first hospital in the world. "How far the little candle throws its beams." Of the woman Fabiola, Leckie said, "The charity planted by that woman's hand overspreads the world and will alleviate, to the end of time, the darkest anguish of humanity."

By 1887, eleven years after its inception, this enterprise of altruism, philanthropy and mercy was established beyond peradventure and steps were taken to bring to fruition a larger plan, because the association had earned the confidence of the community.

It will be a matter of interest to Oaklanders that when the present site was purchased and given by Anthony Chabot, the only objection voiced to the location was that it was too far from the center of things in the city. The success which crowned

the efforts of the good women in charge of the hospital's destinies did not come without great labor and economy on their part, and the institution always had to look at both sides of the family shilling, for at the end of the tenth year, in 1886, the treasurer's report shows a balance on hand of 45 cents.

In 1908 the new surgery, as it is called, was erected and the second phase of the hospital's existence was made manifest and offered another milestone of record of the results of patience, economy and industry, even while combined with altruism and philanthropy.

So many women have given their best thought and time and energy to the welfare of Fabiola Hospital that it is difficult to single out any one of them. However, the names of four stand out: Mrs. Kirkham, whose thought gave birth to the enterprise; Mrs. John Yule, who for twenty-four years guided the destiny of the board and, to whose untiring efforts, more than to the efforts of any other one, must be credited the erection of the first or main building of the present plant; Mrs. Remi Chabot, who directed the activities of the institution from 1908 until 1916; and Mrs. J. P. H. Dunn, who succeeded her mother in 1916 and under whose able leadership the hospital has prospered and grown in size and in quality until now the institution is opening one of the most modern maternity hospitals in the West.

A good modern hospital must have well-equipped clinical laboratories, X-ray laboratories, operating rooms, adequate nursing service and good kitchens in charge of trained dietitians, and all of these we now have. We can hardly compare the little rooms at Nineteenth and Market streets with the present plant, but for that reason all the more must we bare our heads to show the respect due to those women and to the professional staff which made the first beginning possible.

The hospital situation has changed greatly in the intervening years. The Alameda County Hospital, under the trained leadership of a noted hospital authority and with a highly competent professional staff, is no longer the poor house of an older day, and, while still housed in the old building at its old site, is now a splendid institution and before long will be housed in the new Highland Hospital, which will be second to none in the West. Dr. Samuel Merritt devoted much of his fortune to the admirable institution which bears his name and the mercy of his bounty will be exercised as long as this city lasts. The Sisters of Providence have come to Oakland and met another phase of the city's needs in the effective way that their training and opportunities permit them. Both of these and the smaller excellent hospitals about the bay are rendering much free service to the needy sick.

The Oakland Homeopathic Hospital and Dispensary Association may well be proud to acknowledge the Fabiola Hospital of the present day that, without special endowment, without outside support of great moment, thrives under the direction of a devoted board who seek no monetary reward and who, out of the earnings of the institution, have been able year after year to render more than a thousand dollars a month of free service to the needy overtaken by illness.

The torch lighted in 1876, marking the way for untold numbers to health and well-being, is still burning and is carried high to keep bright the traditions of the pioneers of Fabiola.

CONTRA COSTA COUNTY

Contra Costa County Medical Society (reported by L. St. John Hely, secretary)—The annual meeting of the society was held at Hotel Oakland, November 21. A banquet was served, followed by a theater party at the Orpheum, for the following members and guests: Dr. and Mrs. C. L. Abbott, G. M. Bumgarner, H. L. Carpenter, P. C. Campbell, C. R. Leech, E. B. Fitzpatrick and C. R. Blake; Dr. J. T.

Breneman and daughter; L. St. John Hely, Hall Vestal and F. L. Horne, and Miss Agnes Driscoll of the Cottage Hospital.

The following officers were elected for 1924: President, Hall Vestal; vice-president, G. M. Bumgarner; secretary-treasurer, L. St. John Hely.

The subject of group insurance was discussed.

FRESNO COUNTY

Fresno County Medical Society (reported by John D. Morgan, secretary)—The regular meeting of the Fresno County Medical Society was held at the General Hospital of Fresno County on December 4. Forty members were present.

Leo Eloesser of San Francisco spoke on "Surgical Treatment of Septic Condition of the Chest."

James H. Bryant, of Hume, has been elected to membership. Thomas M. Hayden of Fresno was elected to honorary membership. The following resolution was adopted:

"Whereas, After thirty-five years of practice of medicine and surgery in the city and county of Fresno. Thomas M. Hayden has retired from active practice and,

"Whereas, During the entire existence of the Fresno County Medical Society, Thomas M. Hayden has been an active member and an untiring worker in the interests of ethical medicine, now therefore be it

"Resolved, That as a token of esteem and honor held for Thomas M. Hayden by the members of Fresno County Medical Society he is herewith elected to honorary membership in the society; be it further

"Resolved, That a copy of this resolution be spread on the minutes of the society and a copy sent to Thomas M. Hayden with the best wishes of the society."

KERN COUNTY

Kern County Medical Society (reported by P. J. Cuneo, secretary)—Vice-President Moore, in the absence of President Sabichi, presided at the meeting of the society held November 15 in Bakersfield, at the Kern County Hospital. The following members answered to the roll call:

Bacon, Goodall, Gundry, Compton, Rogers, Morris, McNamara, Smith, Hamlin, McKee, Moore, Cuneo, Veon.

Miley B. Wesson of San Francisco was the guest of the society and gave a talk, illustrated by many lantern slides, on "The Kidney and Ureter," which was followed by extended discussion led by Gundry, Moore and McNamara. Hamlin, Morris and McKee were appointed a committee to arrange for the annual banquet, to be held at Stockdale on December 20. It was voted to have the ladies present and follow the meeting by a dance. The January meeting will be held at Taft. Veon, Bacon and Smith are to have charge of the February session.

M. F. Frandy, late of Maricopa, was given a transfer to the Santa Barbara County Society, as he is now a resident of Guadalupe. Kern county regrets to lose Frandy as a member but wishes him all success in his new location.

Leland Ellis has been at Santa Barbara for the last six weeks in attendance upon his mother, Dr. Kathryn Ellis, who has been very ill.

N. Portoghese is now located at San Diego.

E. A. Schapor, who holds membership in our society, although he resides in San Francisco, paid us a visit recently.

C. W. Kellogg, retired, has returned from a several months' absence at Moro Beach.

New Kern County General Hospital—The new hospital being erected at Bakersfield is now about half complete, and the board of supervisors have awarded a bid of \$111,000 for the new Home for the Aged, which is to be a unit of the General Hospital plant, erection to be started at once.

In the past year it has been the policy to isolate

all patients with communicable diseases in the General Hospital, and it has been found highly advantageous, as it has reduced contagiousness 50 per cent.

LOS ANGELES COUNTY

Murphy Memorial Hospital, Whittier—Work has started on the addition to the Murphy Memorial Hospital, and under the personal supervision of Colonel Simon J. Murphy it will proceed until the new wing is ready to turn over to the city for furnishing. This new gift by Colonel Murphy will cost considerably over \$100,000 and will add forty beds to the capacity of the hospital, or a total of ninety. The new wing is being built on the southeast end of the main building and will be four stories in height. Colonel Murphy is quoted in the press as saying: "Our slogan shall continue to be, 'Everything for the patient.' I have been well satisfied with the attitude of the people of Whittier in regard to my wishes to make the standard of this memorial hospital as high as possible, and I believe the hospital staff has been a most decided help in realizing this ambition. For these reasons I am more than happy to be able to again help in giving to Whittier one of the best hospitals on the coast."

Hollywood Hospital—On November 11 members of the staff, officers and employees and the friends of the hospital in general inspected the new plant, after they had been entertained at a ham-and-egg breakfast at the institution. The hospital will have 150 beds, a nurses' home and a laundry.

Seaside Hospital, Long Beach—This excellent hospital is owned and operated by physicians. The earnings of the hospital above 6 per cent are utilized in giving service to those unable to pay. A year ago arrangement was made with the public welfare department of the city by which the hospital would operate an outpatient department for the poor. The hospital furnishes space, equipment and staff and hospital personnel. The welfare department supplies a social service investigator and worker and pays the cost of the medicines and other extras. Three hundred and eighty-five thousand were treated during the year; there were 1202 examinations, 408 special treatments, 102 operations, and 44 patients were fitted with glasses. The public health nurse and social worker connected with the department made 941 home visits to patients.

MERCED COUNTY

Merced County Medical Society (reported by Brett Davis, secretary)—Monthly meeting held in Merced, November 8, with the following present: W. C. Cotton, J. L. Mudd, D. W. Zirker, Brett Davis, C. W. Kohl, E. R. Fountain, Frank W. Yokum, W. E. Lilley, A. S. Parker.

H. A. L. Ryfkogel of San Francisco presented the subject, "The Acute Abdominal Symptoms," first giving the physiology of the gastro-intestinal tract, then the acute conditions of appendicitis, perforation of gastric or duodenal ulcer, biliary and renal colic and acute pancreatitis, differentiating them and stressing the importance of not giving an opiate before a diagnosis is made and not giving laxatives, food or drink while symptoms are acute.

Brett Davis has resigned as city health officer of Merced, and A. S. Parker has been appointed in his place.

There has been a small epidemic of scarlet fever in Merced during October and November.

Merced Hospital, Merced—This newly constructed and equipped hospital was formally opened on November 20. The hospital was financed by a sale of stock under the plan proposed by the League for the Conservation of Public Health, whereby any earnings above 6 per cent must be utilized in rendering service to people unable to pay. The hospital has thirty beds and cost \$60,000. After its completion the trustees leased the hospital to Miss Iva E. Trumbell for a period of five years.

ORANGE COUNTY

Santa Ana Valley Hospital Association—Plans are under way to raise an increased amount of funds for financing the new Santa Ana Valley Hospital. Approximately \$125,000 is already on hand, but an effort will be made by a committee of seventy-five to sell another \$150,000 worth of stock.

PLACER COUNTY

Placer County Medical Society (reported by Robert A. Peers, secretary)—The Placer County Medical Society held its annual meeting in the Masonic Hall, Auburn, December 1. The following members were elected as officers for the year 1924: President, H. N. Miner; vice-president, J. A. Russell; secretary-treasurer, Robert A. Peers; associate secretary, Charles J. Durand; delegate, Sidney J. Talbot; alternate, Harry M. Kanner.

Case reports were made by G. H. Fay, J. G. Mackay, H. M. Kanner, L. B. Barnes, W. L. Whittington, Robert A. Peers.

Owing to the fact that this was the annual meeting, no literary program was presented.

SAN BERNARDINO COUNTY

San Bernardino County Medical Society (reported by E. J. Eytinge, secretary)—The society met December 6 at the San Bernardino County Hospital, with thirty members present, forty-seven absent, and five guests. R. S. Gibbs opened the program with a paper on "Some Special Conditions of Pregnancy"; discussion was opened by W. D. Lenker. Clifford McKee of Los Angeles gave a paper on "A Study of the Uterine Scar following Cesarean Section," and discussion was led by H. W. Mills. Norman Williams of Los Angeles took as his subject, "Cervical Repair on Ninth Day Post-partum"; discussion opened by C. G. Hilliard.

The following new members were welcomed into the society: Walter F. Pritchard (by transfer from Napa County), A. N. Kerr and V. L. Minehart of Arrowhead Springs, and Lenore D. Campbell of Loma Linda.

SAN DIEGO COUNTY

San Diego County Medical Society (reported by Robert Pollock)—In few communities are the relations between the organized medical profession and that of dentistry more closely and harmoniously affiliated than in San Diego. On Tuesday evening, December 11, the members of these two professions, with their wives, enjoyed together an excellent dinner at the San Diego Hotel, after which the following social program was presented: Three-minute speeches by J. E. Jennison, M. D., retiring president of the medical society, and W. E. Walsh, D.D.S., retiring president of the dental society; reading of the elections of the day, the polls having closed at 5 p. m.; brief talks by the newly elected presidents, Andrew J. Thornton, M. D., and F. G. Titus, D.D.S.

The program up to this point was interspersed with vocal numbers by the Orpheus Male Quartet, which were thoroughly enjoyed, and culminated in the address of the evening on the "Meaning of Citizenship," by John P. Buckley, D. D. S., of Los Angeles, ex-president of the American Dental Association. Afterward dancing was enjoyed by those present until a late hour.

Complete returns of the day's election follow:

Medical Society—President, A. J. Thornton; vice-president, Mott H. Arnold; secretary, George B. Worthington; treasurer, C. O. Tanner; councilors, F. H. Carter, M. C. Harding, H. A. Thompson; certified milk commission, W. W. Crawford, R. J. Pickard, R. G. Sharp, H. A. Thompson, A. B. Wesels; delegates, T. O. Burger, W. W. Crawford, Robert Pollock, George B. Worthington; alternates, M. C. Harding, J. C. E. Nielsen, L. H. Redelings, Martha Welpton.

Medical Library Directors—E. A. Blondin, M. M.

Doria, W. H. Geistweit, Jr., M. C. Harding, D. R. Higbee, R. A. Lush, R. J. Pickard, Robert Pollock, L. H. Redelings, Harvey Stallard, W. E. Walsh, George B. Worthington; secretary-treasurer, C. O. Tanner, M. D.

U. S. Naval Hospital, San Diego—Plans have been completed for a \$500,000 addition to the Naval Hospital. This splendid hospital is well located in Balboa Park and is one of the newest and best constructed and best managed of modern hospitals.

SAN FRANCISCO COUNTY

San Francisco County Medical Society (reported by J. H. Woolsey, secretary)—During the month of November the following meetings were held

Tuesday, November 6—Committee on Medicine—Pediatrics—(1) An unusual case of suppurative myositis, Samuel Hanson; (2) An epidemic due to streptococcus infrequens, Edith Boyd; (3) Management of meningococcus meningitis, E. C. Fleischner.

Tuesday, November 13—General Meeting—Nomination of officers for 1924. The Question of Pregnancy in: (1) Nephritis, Alice F. Maxwell; (2) Cardiac disease, Adelaide Brown; (3) Pulmonary tuberculosis, G. H. Evans.

Tuesday, November 20—Committee on Surgery—(1) Some problems in ano-rectal surgery, A. J. Zobel; (2) Citrate blood transfusion and report of 250 cases, E. L. Bruck and LeRoy Brooks; (3) Demonstration of apparatus for reduction of fractures of femur, James Eaves and Paul Campiche.

Tuesday, November 27—Committee on Eye, Ear, Nose and Throat—(1) Demonstration of cases, instruments and methods; (2) A few notes on Halle's clinic with especial reference to his endonasal surgery, Robert D. Cohn; (3) Present aspect of post-graduate and clinic work in Vienna, Warren D. Horner.

William W. Wymore Appointed to the Board of Health—Mayor James Rolph, Jr., has again demonstrated his wisdom by appointing a well-known member of the San Francisco medical fraternity upon the board of health of the City and County of San Francisco. Doctor Wymore graduated from Cooper Medical College in 1895 and during all his professional life he has been engaged in the active practice of his profession in San Francisco. He was a captain in the medical corps of the U. S. Army during the World War. The vacancy which Doctor Wymore is to fill is caused by the completion of fourteen years' service in that position by Dr. George B. Somers.

It may be predicted with confidence that safe, sane, conservative, legitimate medicine and public health will continue to make progress along the right lines with men like Wymore controlling the activities of the City and County Board of Health.

Saint Luke's Hospital Clinical Club—At the regular meeting of the Saint Luke's Hospital Clinical Club of December 4, E. S. Kilgore discussed cardiac neuroses. A. C. Gibson spoke on pan sinusitis and suggestions for treatment at the meeting held December 18.

St. Joseph's Hospital—On December 12 St. Joseph's Hospital staff held its monthly meeting with a varied program. R. M. H. Berndt, T. James and William Quinn presented case histories of patients with post-operative myocarditis, broncho-pneumonia and embolism.

Ethan Smith spoke on hospital notes made on a six months' vacation, including observations in Victoria, Vancouver and Winnipeg, Canada, and in Michigan and Ohio.

W. T. Cummins, director of the clinical laboratories, reviewed the work of his department, showing an increase in different lines, from 75 per cent to 500 per cent. He described new colored sheets for future reports, L. Crowe, director of the X-ray department, gave a resume of his work, and suggestions for future progress. H. Unsinger outlined

the augmented requirements for the library and Newman read the financial account.

On January 9, the "Modern Treatment of Lymphangitis" will be presented by Harry C. Coe, and "Surgical Treatments in Syphilis" by Howard W. Fleming.

University of California Medical Society (reported by William J. Kerr, secretary)—The regular monthly meeting of the University of California Medical Society, held in Toland Hall, University Hospital, on Thursday, November 22, 1923, was attended by more than one hundred members and guests.

J. H. Woolsey of the Department of Surgery presented a case of jejunal ulcer which had followed gastro-enterostomy in a patient suffering from ulcer of the duodenum. The frequency of the condition and symptoms which suggest the possibility of such an ulcer were discussed. Specimens of similar ulcers were shown as well as ulcers at the region of a gastro-enterostomy which apparently resulted from the use of silk as a suture material. A. E. Rockey of Portland was present and discussed the presentation.

Herbert M. Evans of the Department of Anatomy spoke of the vitamin known as vitamin X which he and his co-workers have been able to isolate from plants and food materials. He showed the effect on rats of removing this substance from the diet—the fertility of the animal was seriously interfered with. When the foods containing this substance were added to the diet of these same rats, fertility was re-established.

While Dr. Evans did not feel that this vitamin was much of a factor in the ordinary diet, yet it was of some interest in showing the effects of diet on fertility.

The next meeting of the society will be held Thursday, January 24, 1924. Karl F. Meyer will speak on "Medical and Non-Medical Experiences in Europe During the Past Year," and Drs. Rusk and Woolf will present something of pathological interest.

SANTA BARBARA COUNTY

Santa Barbara County Medical Society (reported by Alex C. Soper, Jr., secretary)—The regular meeting was held Monday, December 10 at the Cottage Hospital, President Means in the chair. Present: fifteen members, two guests, and three internes.

President Means gave a report on his conference with the City Council in the matter of public health questions, and their cordial reception of the aims of the society. Matter also discussed by Freidell, Bagby and O. C. Jones of Lompoc.

George F. Farman of Los Angeles gave a paper on "Some types of chronic recurrent pyelitis and their treatment," which was discussed by Wills, Freidell, Pierce and Sansum.

It was moved by Pierce, seconded by Hotchkiss, that a vote of thanks be extended to Farman for his excellent paper. Passed unanimously.

It was moved by Bagby, seconded by Schurmeier, that the annual banquet in January be held at the Hotel Samarkand. Passed unanimously.

SISKIYOU COUNTY

Siskiyou County Medical Society (reported by C. C. Dickinson, secretary)—At the last regular meeting of the Siskiyou County Medical Society, held in Yreka, November 12, 1923, the following officers were elected for the ensuing year: President, C. W. Nutting, Weed; vice-president, F. B. Lucas, Hilt; secretary-treasurer, C. C. Dickinson, McCloud.

SONOMA COUNTY

Sonoma County Medical Society (reported by N. Juell, secretary)—On December 13 the society met

at Petaluma with twelve members present, twenty-five absent; four visitors. E. W. Cleary of San Francisco delivered an address on "Fractures," with illustrations.

Fifty dollars was voted to be sent to aid suffering German medical men. G. S. Holeman was transferred to Centerville, Alameda county. G. W. Mallory, a charter member of this society, was re-elected to membership.

The following officers were elected for 1924: President, Alfred A. Thurlow, Santa Rosa; vice-president, A. M. Thomson, Sonoma; secretary, N. Juell, Santa Rosa; treasurer, R. M. Bonar, Santa Rosa; censors, F. O. Pryor, Santa Rosa, J. H. McLeod, Santa Rosa, J. W. Cline, Santa Rosa; delegates, H. L. Rogers, Petaluma; alternate, F. O. Pryor, Santa Rosa.

The meeting was followed by a banquet.

STANISLAUS COUNTY

Stanislaus County Medical Society (reported by R. E. Maxwell, secretary)—The Oakdale members of the society entertained the members of the society and their ladies at a turkey dinner, which was served by the culinary department of the Oakdale high school. The following members were present: C. J. Bemis, C. E. Benson, J. A. Cooper, F. R. DeLappe, E. V. Falk, C. E. Finney, E. F. Hagadorn, F. R. McKibbin, President E. R. McPheeters, J. W. Morgan, secretary pro tem, C. E. Pearson, F. J. Peters, E. F. Reamer, B. F. Surryhne, and J. A. Young.

H. G. Mehrtens of San Francisco read a paper on "Neuro-Syphilis, with Technique of Swift-Ellis Treatment." The subject was exceptionally well handled.

E. G. Allen was admitted to membership in the society.

A committee on insurance was appointed, following talks on the subject by representatives of the Medical Protective and Aetna companies.

A vote of appreciation and thanks was given the Oakdale school board for the use of the school for the meeting.

Roentgen-Ray Intoxication—S. L. Warren, San Francisco, and G. H. Whipple, Rochester, N. Y. (Journal A. M. A., November 17, 1923), state that evidence from animal experiments and scattered clinical observations is convincing that the human intestinal mucosa is peculiarly sensitive to the hard and short-wave length Roentgen rays. A similar condition obtains in the common laboratory mammals. It is probable that the intestinal epithelium is at least as sensitive as the skin epithelium, and it may be more so when its increased distance from the Roentgen-ray target and the intervening body tissues are considered. Erythema doses or larger doses given over the abdomen or intestinal areas may cause injury to this sensitive intestinal epithelium. The authors urge particular care should be used when "cross-fire" is used over areas including intestinal coils, as the loops may be seriously injured. Local Roentgen-ray injury to intestinal coils may not give rise to severe clinical intoxication, but may cause ulcers that are no less chronic and dangerous than are the familiar Roentgen-ray skin "burns." It is very desirable that all cases in which erythema or larger doses are given over the abdomen be very carefully studied and reported so that our knowledge as to the danger limits may be comprehensive. Until such time, we must use the data obtained from controlled animal experiments. Such experiments indicate that the intestinal epithelium is quite sensitive to hard irradiation. These facts should receive careful consideration by the radiologist who contemplates radiotherapy of abdominal areas (for example, pelvic tumors).

THE FUNCTION AND PROPER FIELD OF ACTIVITY OF THE PUBLIC HEALTH OFFICER

In promoting the betterment of public health, Leverett D. Bristol, Olean, N. Y. (Journal A. M. A., Nov. 24, 1923), says the private practitioner and the public health official must co-operate to bring about desired results. While special functions and fields of activities of health officers and private practitioners may differ, their objects and aims are the same—to promote positive health for all members of society and to relieve the more unfortunate persons of disease and suffering. The local board of health is the oldest and the most responsible public health unit. As its chosen executive officer, the local health officer should be the public health leader and educator of his community. In those States having laws permitting the employment of county health officers or general district health officers for counties, such health officers possess all the powers and duties conferred on local health officers within their particular jurisdictions.

There are two forms of State health organizations, one in which the power and authority is vested in a State board of health, consisting of several part-time officials, which employs a secretary or executive officer usually on a full-time basis. Some of the more progressive States, have reorganized State health work in such a way that the chief power is vested in a commissioner who has the assistance of an advisory council. The outstanding need in entire future health programs is that which has to do with rural public health and sanitation, and its adequate development throughout the State. In general, it may be said that, while there has been a gradual decline in the death rate in the cities, the death rate in country communities has remained fairly stationary.

In addition to carrying on educational work, State health authorities may have other important functions and fields of activity, such as: (1) investigation and research of various kinds; (2) epidemiologic and laboratory diagnostic service; (3) standardization of methods and forms; (4) fixing of professional standards for the qualifications of health officers; (5) supervision of schools or courses of instruction for health officers; (6) popular publicity work; (7) the control of communicable diseases or nuisances affecting more than one community or district; (8) the recording of vital statistics; (9) the inspection and control of foods and drugs; (10) the examination and control of public water supplies and sewage disposal plants; (11) supervision over the manufacture of antitoxins and vaccines; (12) supervision over hospitals and sanatoriums for tuberculosis; (13) supervision over maternity, infancy and child hygiene work, and (14) supervision over public health nursing service.

The most essential requirement for the ultimate success of public health administration, local, State and Federal, is a sympathetic co-operation between the private practitioners of medicine and surgery and the public health authorities. The private practitioner of medicine is potentially the most important unit in public health work. If the private practitioner has failed in the past to take his proper place and to assume his true function in preventive medicine, it is because of the fact that he has thought too much of his individual rights and prerogatives and too little of his obligations and responsibilities to the public. His chief obligations are:

1. Legal obligations, including: (a) The prompt and accurate reporting of births, (b) The prompt and accurate reporting of deaths, (c) The prompt and accurate reporting of all diseases required to be reported. 2. Professional or moral obligations, including: (a) Early and accurate diagnosis, (b) Prompt and efficient treatment, (c) Education of his patient as to the patient's future needs, and as to the patient's own relation to the health of the com-

munity, (d) Co-operation with the constituted health authorities.

What is needed is not "State medicine," but organized medicine; medicine which is organized in such a way that, while it remains largely in the hand of private practitioners, it will reach rich and poor, city folk and country folk, children and adults, not only after disease has gained a foothold, but before disease has become apparent, and while the individual is yet well and strong. The practitioner of the future must work and think more in terms of physiology and less in terms of pathology.

In the medical schools of the past and present, the departments of pathology have been and still are the outstanding and most popular departments, while those of preventive medicine have had to fight for existence. In the medical schools of the future, the departments of pathology must naturally fade into insignificance compared to the growing departments of physiology, hygiene and preventive medicine. Let the curriculum makers give less time to the "dead house" and cirrhotic livers and more time to the houses of the living and the principles of hygiene.

SAFE MILK

There is less public discussion about "safe" milk than there was a few years ago. Recognition of the importance of milk as a food and of the fact that it has to be carried long distances to market has established the principle that milk sanitation is a necessity. The procedures involved have at length become fairly well "standardized." Foremost are:

1. Prevention of all possible contamination by those handling the milk on the farm and in the dairy and by proper care of the cow. The utmost refinement of this plan is observed in the production of certified milk or its equivalent, produced and cared for under exceptionally sanitary conditions, and constantly supervised and inspected by a medical milk commission.

2. Pasteurization by one of a variety of commercial methods. Its use has greatly increased in recent years. The general tendency is toward the pasteurization of all market milk except the certified milk, and in some large cities it is compulsory.

Tuberculosis is the commonest disease with which cows are affected, and therefore demands particularly careful consideration in connection with milk, although the other possibilities of milk-borne infectious agencies are not by any means negligible. It is pertinent to inquire from time to time, therefore, whether commercial pasteurization conducted, as it must be, on a large scale, actually destroys tubercle bacilli.

A careful investigation in a representative American city has shown the presence of these microorganisms by actual inoculation tests in specimens of the raw milk of average quality delivered to city dealers. It was also demonstrated that pasteurization by the holding process between 142 and 148 F. for thirty minutes destroys the tubercle bacillus in the milk. The commercial process of rendering the milk safe can readily be made efficient; it should never be allowed to fail wherever dependence is placed on pasteurization.—Journal A. M. A., Nov. 24, 1923.

A New Procedure for Performing Litholapaxy—

Albert E. Goldstein, Baltimore, and J. Fletcher Lutz, Glenn Rock, Pa., (Journal A. M. A., December 8, 1923), are of the opinion that in an uncomplicated case of vesical calculus lithotripsy or litholapaxy is the operation of choice. They have devised a method by which the operation is made a safe and rapid procedure, and at the same time visualized without the aid of the cystoscope. This is performed by combining litholapaxy with fluoroscopy in an air medium. The operation is always under the control of the eye, making it a rapid and safe procedure. Accidents and burns are negligible.

YOUR STATE JOURNAL

The journal of your State society is your own publication and the official organ of your own society, writes F. C. W. in the A. M. A. Bulletin of October, 1923. As such it deserves your active support. If it is not so good as you think it should be, you can help to make it better. The State journal serves for the publication of scientific papers presented at the meetings of the State association and of county district medical societies, for recording and commenting on professional and organizational activities, for maintaining contact between component societies and their members throughout the State and for keeping its readers informed about the comings and goings and the fortunes, good or bad, of their fellows in the State; and it serves also as a forum for the discussion of professional problems of the times.

You can lend real support and constructive assistance to your State journal in many ways. A few suggestions as to how your personal assistance may be extended are here offered:

1. See that what you write contains more than just a grouping of quotations and trite observations. Make it reflect your personal experiences and results. Strive to make your every-day work produce something that will be helpful to your fellows in their professional labors and try to impart to them the worthwhile things that you have learned in the pursuit of your professional duties.

2. Read the editorials in your journal, and if you have personal opinions that are not selfish, tell the editor about them. Discuss with him and with your fellow-members the problems of the day in your community and State, and record your judgment as to the best solution of these problems.

3. Urge the officers of your county medical society to report the meetings of the society and the activities of the profession in the county to the journal. If these officers are overburdened, offer them your aid in the preparation and transmission of such reports.

4. Let your friends in the profession throughout the State know what the physicians in your community are doing. Send news notes and items of social interest to the editor of the State journal. Your professional friends are interested in you, and the State journal can promote and maintain friendly associations throughout the State if you will help do it. Your friends want to know when you are married, when you become a proud father, when your community honors you, when good fortune shines on you, and, yes, when you are dead. If you are not heard from, they may think you dead.

5. Your annual dues and the dues of your fellow-members in the State medical association do not produce nearly enough money to pay the cost of your State journal. The editor and his associates are constantly busy making up the difference, by securing advertising contracts. These can be secured, but they cannot be continued in force unless the other persons interested in them, the advertisers, receive returns on their investment in your journal. Those products advertised in the State journal are dependable, because none but reputable concerns are permitted to advertise. When you buy what is advertised in your State journal, you buy standard products.

6. Read your State journal from cover to cover. Probably this should have been our first suggestion. At any rate, it is desired to impress you with its importance. The reaction will come which will bring about improvement in a poor journal, if any such there be, and will make a good journal better if the members of the State association will read it. Even in the poorest, there will always be found something helpful.

No matter how busy you are, your State journal and The Journal of the American Medical Association should be read at the first opportunity after they are received. The busier you are, the more you need to read them. The physician who does

not read these journals is the man who does not progress—in fact, he is the man that retrogresses.

It is hoped that, in thus calling the attention of the readers of the Bulletin to the State medical journal, an expression of renewed interest in their State medical publications will be evoked from our Fellows. As this interest manifests itself, we will witness the development of a greater solidarity and greater unity of purpose, and of effort in medical organization and in scientific progress.

The Treatment of Neurosyphilis—The problem of the treatment of neurosyphilis according to H. C. Solomon, Boston (Journal A. M. A., Nov. 24, 1923), is to destroy the spirochetes that are present in the nervous system. The nervous tissue is walled off from the general body structures, and this leads to a relative impermeability of drugs placed in the general circulation. However, some penetration takes place, the amount apparently varying in different individuals. There is a group of neurosyphilitic cases that react well to mild systemic treatment. Others require more intensive systemic treatment. There are many, however, that are not improved to any extent by systemic treatment with arsphenamin, mercury or iodid. Some of these cases do well, however, when medicaments are given directly into the cerebrospinal fluid or when spinal drainage is used. Theoretically and practically, it seems advisable to place the medicament as near to the site of pathologic change as possible, utilizing the lumbar subarachnoid space, the region of the cisterna magna and the ventricles as conditions indicate.

No definite rules can be laid down as to which type of treatment will produce the best results in a given case. A classification based on the reaction to treatment does not coincide with the older ideas of tertiary syphilis of the nervous system as contrasted with parasyphilis, because some cases of tabes and paresis react quite well to relatively mild systemic treatment, whereas some cases of the meningovascular group do poorly on the same type of therapy. It is more difficult on the whole, to get satisfactory results in cases of tabes and general paralysis than in the meningovascular type, and the former usually require quite intensive treatment, making use of the cerebrospinal fluid pathway. There still remains a group of cases that cannot be satisfactorily modified by treatment with arsphenamin, mercury, the iodids and blood serum. The immunity of the patient plays a large role in the results obtained, and various procedures that may increase the immunity responses have a place in the treatment of neurosyphilis. Of great importance are all hygienic procedures that improve the general condition of the patient. Some favorable reports have been made from inducing febrile reactions by inoculations with malaria and relapsing fever. The hope for the future rests either in the method of inducing greater immunity on the part of the patient or in developing drugs with greater power of permeation into the nervous tissue.

The Treatment of Urethral Stricture by Excision

—The history of urethral stricture as it is recorded in medical literature is reviewed by Granville MacGowan, Los Angeles (Journal A. M. A., December 1, 1923), and the technic of its repair is discussed in detail. In the author's operation, the intention is to restore the tube by approximating its cut ends in their entire circumference, and this, he says, is best achieved not by the laying of a circular stitch, such as was done by Mayo Robson with success after the excision of an annular stricture where the loss of structure was not more than one-fourth inch, and as was the practice of König, but by slitting the urethra and spongy body both anteriorly and posteriorly into three strips, or ribbands, one posterior and two lateral, using great care not to mangle the tissues and to have clean incisions. MacGowan reports no failures from the use of this method.

Utah State Medical Association

J. R. MORRELL, M. D., Ogden - - President
 WILLIAM L. RICH, M. D., Salt Lake - Secretary
 W. R. CALDERWOOD, M. D., Associate Editor for Utah

University of Utah Medical School Inspected—A committee appointed by the Utah State Medical Association has made a thorough inspection of the University of Utah medical school. This committee, composed of leading doctors of the State, was created last June at the suggestion of President George Thomas, of the university, and Ralph O. Porter, dean of the medical school. It is to inquire into the work given at the medical school, thereby permitting constructive suggestions and criticism, and to actively co-operate in making the first two years of the university medical course equal to similar work at any medical school in the United States.

Although the committee has not yet made an official report, it was evident from the remarks of the individual doctors that they were well pleased and in some instances very much surprised at the quality of work required of medical students.

Dr. Porter declares that lack of active co-operation between the medical school and the medical profession of Utah has in the past hindered the proper development of the school, but judging from the interest now shown by the doctors, that difficulty has largely been overcome.

During the past year many changes have been made in the school. The faculty has been materially strengthened, and much needed equipment added. Classes are limited to twenty-five students, and the selection is made purely on the basis of scholarship.

Members of the committee were: J. W. Morrell of Ogden, president of the Utah State Medical Association; J. C. Landenberger of Salt Lake, former president of the association; Sol Kahn, president-elect of the association; Francis A. Goeltz, president of the Salt Lake County Medical Society; Robert Hampton, Salt Lake; E. F. Root, Salt Lake; H. P. Kirtley, Salt Lake; Clarence Snow, Salt Lake. They were accompanied on their tour of inspection by Dean Porter and President Thomas.

New Members of Utah State Medical Association—A. A. Anderson, Templeton Bldg., Salt Lake City; P. M. Chase, McCornick Bldg., Salt Lake City; R. G. Frazier, Bingham Canyon; B. L. Kesler, Bountiful; Paul Richards, Bingham Canyon; George E. Robison, Boston Bldg., Salt Lake City; G. W. Rutledge, Kaysville; Henry Rite, Sugar House; John W. Sudgen, Judge Bldg., Salt Lake City; F. R. Slopansky, Boston Bldg., Salt Lake City; George A. Anderson, Springville; B. C. Linbaugh, Pleasant Grove; L. C. Potter, Provo; L. D. Stewart, Payson; A. G. Stoddard, Spanish Fork.

Salt Lake County Medical Society (reported by F. F. Hatch, secretary)—The last regular meeting of the Salt Lake County Medical Society for the year 1923 was held on December 10.

The secretary F. F. Hatch, read his report which was accepted with the following corrections: That Roy Groesbeck ends his service as censor of the society with this meeting; that the late A. S. Bower's death be noted in the secretary's report with the additional information that the society's regrets were submitted to the family at that time; that the delegates now in office remain on the rolls until new ones are elected in June, 1924.

The treasurer's report by V. J. Clark was read and ordered filed.

Report of the Library Committee was given by Chairman W. R. Tyndale. In speaking concerning this committee, S. C. Baldwin reported that the transactions of the American Orthopedic Associa-

tion could be had for the asking. It was moved, seconded and passed that Baldwin's recommendation be added to the report and the report filed.

The Medical Legal Committee, with E. F. Root as chairman, gave a verbal report, which was accepted and a motion was made accepting it, which was carried.

The Liability Insurance Committee reported, B. W. Black, chairman, that this or a similar committee be held over as they have been in office only two weeks, and should complete the work started. Moved, seconded and carried that the report be accepted and the committee continued.

The Committee on Public Health and Legislation was reported on by John Z. Brown, the chairman, orally, which report was accepted by the society.

The amendment to the By-Laws, as stated fully in the last meeting's minutes, was accepted and carried unanimously, making the fiscal year of the society begin January 1 with dues payable then, and making members delinquent on February 1. This means delinquent members would have to pay \$12 dues—an additional \$2 for reinstatement, the regular dues of the society being \$10.

Motion was made appointing an Auditing Committee. Seconded and carried and the chair appointed A. A. Kerr, chairman, L. N. Ossman and Edward LeCompte as this committee.

There was a discussion of the Baby Clinic by Thomas Clark, who made a motion to appoint a committee to study the Baby Clinic in the City Board of Health's Department and consult with Christopherson and Commissioner Barnes in regard to its continuance. This motion was amended by M. M. Nielson, that the committee investigate all hospitals treating charity cases. The amendment was accepted in the original motion and was carried unanimously.

The officers for the year 1924 were elected as follows: A. A. Kerr, president; John Z. Brown, vice-president; M. M. Critchlow, secretary; Joe Jack, treasurer; F. A. Goeltz, censor.

Utah County Medical Society (reported by Fred R. Taylor, secretary)—At the last regular meeting of the Utah County Medical Society, G. Gill Richards of Salt Lake gave a very interesting and comprehensive paper on the Insulin Treatment of Diabetes. His paper was supplemented with case reports and an exhibition of some of the common diabetic foods.

The following new members were admitted to membership in the society—J. W. Bergstrom, Cedar City; George C. Nelson, Loa; George H. Mott, Santaquin; Thomas D. Rees, Nephi. Plans were also completed for the handling of the Utah County Free Clinic.

Weber County Medical Society (L. R. Draper, secretary)—The annual banquet and election of officers of the Weber County Medical Society was held at the Weber Club, Ogden, Utah, Tuesday evening, December 18. In place of the usual program of after-dinner speakers, a short vaudeville performance was given, which was enjoyed by all members and visiting physicians.

E. G. Hughes counselor of Provo; A. A. Kerr, president of the Salt Lake Medical Society, and Samuel Baldwin of Salt Lake were guests at the meeting.

Preliminary arrangements were made for a closer co-operation between the Weber County Medical Society, the Salt Lake County Society and the Utah County Society.

The following officers were elected for the ensuing year: President, W. A. Whitlock, Layton, Utah; vice-president, F. K. Bartlett, Ogden; secretary and treasurer, L. R. Draper, Ogden.

Nevada State Medical Association

HORACE J. BROWN, M. D., Reno.....President
 CLAUDE E. PIERSALL, M. D., Reno....Secretary-Treas.
 G. L. SERVOS, M. D., Reno...Assoc. Editor for Nevada

ABSTRACTS FROM NEVADA MEDICAL BULLETIN

(Editor, Horace J. Brown, 14 Thoma-Bigelow Building, Reno, Nevada)

November 15—It may seem a little early to begin talking about the 1924 meeting but your incoming officers are so anxious to please you in the matter of the time and place for holding it that they feel that it is not too soon to begin asking your wishes about it. We want to so arrange it that the greatest possible number can attend, and we would like to have an expression from every member. Eight of our members favored us with papers at the last meeting and we hope to have twelve next year. On a recent visit to the editorial office of the California Journal, they requested the names of our members, with their specialties designated, so that they can ask us to write discussions of papers to be published by them. Our members will be asked to discuss the papers read at our recent meeting. Each of our members will receive a copy of the December issue, complimentary, and the January issue will go to all that have paid dues in advance at the new rate of \$7 per year. The new arrangement of membership and the California Journal for \$7 seems to be quite popular, as we have had five new applications for membership recently. Here-to-fore county secretaries have sent \$3 for each member to the State Association but for 1924 they should send \$5, and we hope they will remit promptly, when they collect the dues, so that the secretary can send the names of those paid in advance to the California Journal.

December 1—The California Medical Journal is undoubtedly one of the best State journals and we should be able to get lots of good ideas out of it during the coming year. Each issue will have a page set aside for our use and we can fill all, or any part of it with news and announcements of especial interest to Nevada. Dr. George L. Servos, 150 N. Virginia street, Reno, will be the Associate Editor for this State and he will appreciate it very much if all those that have news items, or other interesting matter, will send same to him. We mentioned in a previous issue that professional cards will be accepted for the advertising columns, at the rate of \$30 per year or \$20 for six months. There are several of our members that will probably wish to take advantage of this offer, and they can either write to Dr. Musgrave or to our secretary. We had the opportunity to ask three members from various points in the State as to where the 1924 meeting should be held and they are unanimous in naming Bowers Mansion. They all seem to have had quite an enjoyable time out there and want to go back again. We would like to hear from every member on this subject, and also as to the time for holding the meeting, as we want to set the time and place as early as possible in the New Year. We have the promise of two papers as a starter for the program and hope to hear from several other prospective essayists in the near future. Don't forget that you must have your dues paid in advance if you expect to receive the California Journal and if your conscience hurts you about 1923 dues you can relieve it by sending a check for \$12 to the secretary. Please don't delay as the retiring secretary would like to turn over a clean set of books to his successor.

Nevada News Items

M. R. Walker, Reno, has been appointed assistant surgeon for the Southern Pacific Co., for the Reno district.

Anna B. DeChene, Reno, has been appointed Councilor for Nevada of the Medical Womens' National Association.

The following officers were elected for 1924 by the Washoe County Medical Society: President, Rodney H. Richardson; vice-president, L. V. Smith; secretary-treasurer, V. A. Muller; councilors, G. L. Servos and C. W. West.

C. W. West, retiring president of the Washoe County Medical Society, entertained the members of that body at his home, following the monthly meeting on December 4.

Five applicants appeared before the Board of Medical Examiners on November 5, four of whom passed and one failed.

F. F. Owens, Ely, College of Physicians and Surgeons, New York, 1896, was found dead in his office on November 23. He was 51 years of age.

W. F. Boylan, Bridgeport, California, Eclectic Medical Institute, Cincinnati, 1891, died November 26; after a few days' illness from heart disease. He was 55 years old.

The following new members have been admitted to the association since the annual meeting: R. S. Tillotson, East Ely; W. H. Frolich, East Ely; J. H. Hastings, Pioche; George Pearn, Jarbridge, and George R. Magee, Yerington.

D. A. Smith, Mina, has been appointed county physician of Mineral county. J. W. Davis has resigned.

J. B. Wilson has removed from Lovelock and will locate at some point on the coast, probably at Los Angeles.

New Experiments on Rejuvenation—The Journal has commented on the experiments of Steinach and others in the rejuvenation of animals presumed to follow ligation of the vas. Recently Macht and Teagarden of Johns Hopkins University have performed similar operations on six rats, all more than a year old and showing definite signs of senescence. These were compared with two other animals used as controls. Fourteen additional rats were studied by special methods involving the use of animals operated on and adequate controls. The details of the method leave no doubt as to the scientific character of the experiments. After ligation, a number of the rats showed distinct improvement in general appearance and behavior. They were more active, and several developed a new coat of fur. These changes persisted only for several weeks, however, and the animals gradually relapsed into their usual senile state. Also distinct improvement in muscular co-ordination and muscular efficiency of the animals was noted, but this was temporary, lasting only a few weeks. It is the belief of the observers that all the changes noted seemed to have been the results of the operation; they assert, nevertheless, that this cannot be said positively without numerous additional experiments. This work would seem to confirm the impression now prevailing that the various rejuvenation experiments constitute at best only a temporary stimulus, and that the inevitable result is relapse, if not, perhaps, a shortening of life because of additional burdens thrown on a senescent organization.—Journal A. M. A., Nov. 24, 1923.

Expect to be called a standpatter, but don't be a standpatter. Expect to be called a demagogue, but don't be a demagogue. Don't hesitate to be as revolutionary as science. Don't hesitate to be as reactionary as the multiplication table. Don't expect to build up the weak by pulling down the strong. Don't hurry to legislate. Give administration a chance to catch up with legislation.—President Calvin Coolidge's political creed.

BOOK REVIEWS

Non-Surgical Drainage of the Gall-Tract. A treatise concerned with the diagnosis and treatment of certain diseases of the biliary and allied systems, in their relation to gastro-enterology and general clinical medicine. By B. B. Vincent Lyon, M.D. 640 pages. Illustrated. Philadelphia and New York: Lea & Febiger. 1923. Price, \$10.

Although this volume of 623 pages is entitled the non-surgical drainage of the gall-tract, the author states in his preface that he has two major purposes, the first to present to the medical profession in more complete form the diagnostic and therapeutic value of non-surgical drainage of the biliary system, etc., and the second to present the author's plan of a systematic and practical method of studying the gastro-intestinal tract as a whole. He then proceeds at great length and in great detail to accomplish his major purpose, with here and there a pause for the development of some minor purpose, such as a six or seven-page discussion of Giardia infection.

Approximately 150 pages are devoted to the diagnostic and therapeutic uses of non-surgical drainage of the gall-tract, with an additional 123 pages of illustrative case histories.

There can be no question but that this procedure has a definite place in the study and treatment of biliary tract disease, but it remains for the future to determine its exact value. From the diagnostic standpoint, the procedure requires extreme care and attention to detail, as emphasized by the author, but even then I fear the findings, especially the bacteriologic, may be misleading.

The remainder of the book is devoted to chapters on the embryology, anatomy, histology, and physiology of the biliary system and to various chapters dealing with methods of study and treatment of gastro-intestinal condition in general and biliary-tract conditions in particular.

The whole subject matter is well presented, but I believe would have been of greater service if the author had kept strictly to the first of his major purposes, reserving the second for a separate volume.

W. W. B.

A Manual of Proctology. By T. Chittenden Hill. 279 Pages. Illustrated. Philadelphia and New York: Lea & Febiger. 1923. Price \$3.25.

A short practical compendium, containing considerable information and considerable misinformation. Some of its statements are founded on hearsay evidence accepted by the author with too little inquiry. However, the book tells what to do and how to do it in a simple and readable way, so that it will probably find a large audience.

L. E.

Alcohol and Prohibition, In Their Relation to Civilization and the Art of Living. By Victor G. Vecki, M.D. Philadelphia and London: J. B. Lippincott Company.

This book ought to have a wide circulation; certainly every physician ought to read it, and other citizens will find much in it to think about. Not all physicians will agree with everything that Vecki says, but they certainly will give him credit for an honest expression of opinions, presented in an interesting and attractive manner.

W. E. M.

The Tonsils—Faucial, lingual, and pharyngeal. With some account of the posterior and lateral pharyngeal nodules. By Harry A. Barnes, M.D. Second edition, 217 pages. Illustrated. St. Louis: C. V. Mosby Co. 1923. Price \$5.

This is a well-edited, readable book. The chapters

on histology and pathology are excellent and much the strongest. The chapters on surgery are not of the same high standard and all will not agree with the author's views on the relative merits of local and general anesthesia, methods of inducing local anesthesia, position of patient during operation, and methods of controlling post-operative hemorrhage.

A Primer for Diabetic Patients. A brief outline of diabetic treatment including directions for the use of insulin, sample menus, recipes, and food tables. By Russel M. Wilder, M. D., Mary A. Foley, Dietician, and Daisy Ellithorpe, Dietician. Second edition, 119 pages. Philadelphia: W. B. Saunders Co. 1923.

An excellent little manual. It tells the patient exactly what he should know. He has a homely way of putting information that is peculiar to the Mayos. •It is equally well suited to a diabetic college professor or a diabetic Minnesota farmer.

L. E.

BOOKS RECEIVED

Alcohol and Prohibition in their Relation to Civilization and the Art of Living. By Victor G. Vecki, M. D., San Francisco. Philadelphia and London: J. B. Lippincott Co.

Collected Reprints, from the George Williams Hooper Foundation for Medical Research. The Department of Medical Research of the University of California Medical School, San Francisco. Volume VII, 1922-1923.

Hygiene and Public Health. By Louis C. Parkes, M. D., Consulting Sanitary Adviser to H. M. Office of Works, Fellow of the Royal Sanitary Institute, and Henry R. Kenwood, C. M. G., M. B., Chadwick Professor of Hygiene in the University of London. Seventh edition with illustrations. Philadelphia: P. Blakiston's Son & Co., 1923.

Mental Disorders, an Introduction to the Study of. By Francis M. Barnes, Jr., M. D., Associate Professor of Nervous and Mental Diseases in the St. Louis University Medical School, etc. Second Edition. St. Louis: C. V. Mosby Co., 1923.

Diagnostic Methods. A guide for history taking, making of routine physician examinations and the usual laboratory tests necessary for students in clinical pathology, hospital internes and practicing physicians. By Herbert Thomas Brooks, M. D., Professor of Clinical Medicine, College of Medical Evangelists, Los Angeles, formerly Professor of Pathology, College of Medicine, University of Tennessee. Fourth edition, with fifty-two illustrations. St. Louis: C. V. Mosby Co., 1923.

Modern Aspects of the Circulation in Health and Disease. By Carl J. Wiggers, M. D., Professor of Physiology in the School of Medicine of Western Reserve University, Cleveland Ohio. Second edition, thoroughly revised. Illustrated with 204 engravings. Lea & Febiger, Philadelphia and New York, 1923.

A Treatise on Orthopaedic Surgery. By Royal Whitman, M. D., Surgeon to the Hospital for Ruptured and Crippled; Consulting Orthopaedic Surgeon to the Hospital of St. John's Guild, etc., seventh edition thoroughly revised. Illustrated with 877 engravings. Lea & Febiger, Philadelphia and New York, 1923.

Local Anaesthesia Methods and Results in Abdominal Surgery. By Hans Finsterer, Surgeon-in-Chief, Vienna Hospital of the Brothers of Charity,

Authorized English version by Joseph P. F. Burke, M. D., Attending Surgeon, Buffalo Hospital of the Sisters of Charity and Buffalo City Hospital. Forty-two illustrations. New York: Rebman Co.

The Medical Department of the United States Army in the World War, Volume V. Military Hospitals in the United States. Prepared under the direction of Maj. Gen. M. W. Ireland, M. D., Surgeon General of the Army, by Lieut. Col. Frank W. Weed, M. C., U. S. Army. Washington: Government Printing Office, 1923.

A Critical Examination of Psycho-Analysis. By A. Wohlgenuth, D. Sc. (Lond.) New York: The Macmillan Co., 1923.

Diseases of the Skin. By Richard L. Sutton, M. D., Professor of Diseases of the Skin, University of Kansas School of Medicine; former chairman of Dermatological Section of the American Medical Association; Assistant Surgeon, U. S. Navy, retired. With 1069 illustrations and 11 colored plates. Fifth edition, revised and enlarged. C. V. Mosby Co., St. Louis, 1923.

Nutrition and Clinical Diets. By Herbert S. Carter, M. D., Assistant Clinical Professor of Medicine, Columbia University, Consulting Physician to Presbyterian Hospital, Lincoln Hospital, Skin and Cancer Hospital, New York; Paul E. Howe, Ph. D., Associate, Rockefeller Institute for Medical Research; Howard H. Mason, M. D., Associate in Diseases of Children, Columbia University, New York, Visiting Physician, Children's Service, Presbyterian Hospital, New York. Third edition, thoroughly revised. Lea & Febiger, Philadelphia and New York, 1923.

A Manual of Proctology. By T. Chittenden Hill, M. D., Instructor in Proctology, Harvard Graduate School of Medicine, surgeon to Rectal department, Boston Dispensary. Illustrated with 84 engravings. Lea & Febiger, Philadelphia and New York, 1923.

The Treatment of Diabetes Mellitus, with observations based upon three thousand cases. By Elliott P. Joslin, M. D., Clinical Professor of Medicine, Harvard Medical School; Consulting Physician, Boston City Hospital. Third edition, enlarged, revised and rewritten. Illustrated. Lea & Febiger, Philadelphia and New York, 1923.

Diseases of the Skin. By Frank Crozer Knowles, M. D., Professor of Dermatology, Jefferson Medical College; Dermatologist to the Philadelphia General, The Presbyterian, The Children's and The Babies' Hospitals. Second edition, thoroughly revised. With 229 illustrations and 14 plates. Lea and Febiger, Philadelphia and New York, 1923.

Kurzes Lehrbuch der Chemie in Natur und Wirtschaft, von Prof. Carl Oppenheimer, Dr. phil. et. med., Berlin, nebst einer Einführung in die Allgemeine Chemie, von Prof. Johann Matula in Wien. Georg Thieme, Verlag, Leipzig, 1923.

Über Hysterie, von Dr. Ernst Kretschmer, Privatdozent für Psychiatrie in Tübingen. Leipzig, 1923. Verlag von Georg Thieme.

Medizinische Psychologie, Ein Leitfadens für Studium und Praxis, von Dr. Ernst Kretschmer. Zweite Auflage. Mit 22 Abbildungen. Leipzig, 1922. Georg Thieme, Verlag.

Diagnostische Technik für die ärztliche Praxis, ein Handbuch für Ärzte und Studierende. Herausgegeben von Professor Dr. Julius Schwalbe Geh. San.-Rat Mit 380 Abbildungen. Leipzig, 1923, Verlag von Georg Thieme.

HOSPITAL EXTENSION WORK

The following schedule of operative and dry clinics in the teaching schools and accredited hospitals of California will be found of service to graduate physicians in general practice who desire to avail themselves of the opportunity for observation and study:

Stanford University Hospital, San Francisco (Operative Clinics)

Practical work in clinics and laboratories open to physicians during July, August, and September.

Surgery—Tuesday, 8 a. m. to 12 m.; 1:30 p. m. Thursday, 8:30 a. m. to 12 m.; 1:30 p. m. Saturday, 8:30 a. m. to 12 m.; 1:30 p. m.

Genito-Urinary—Monday, 8:30 a. m. to 12 m.; Friday, 8:30 a. m. to 12 m.

Gynecology—Tuesday, 1:30 p. m.; Wednesday, 8:30 a. m.; Friday, 1:30 p. m.

Nose and Throat—Monday, 1:30 p. m.; Wednesday, 1:30 p. m.

Orthopedic (Class)—Monday, 2 p. m.; Friday, 10 a. m. to 12 m.

Eye—Wednesday, 1:30 p. m.

Stanford University Medical School, San Francisco (Medical Clinics)

General Medicine—Wednesday, 11:30 a. m.

Obstetrics and Gynecology—Saturday, 11:30 a. m. Clinico-Pathological Demonstrations—Monday, 11:30 a. m.

Colloquia at San Francisco Hospital

(Programs posted in Lane Medical Library and County Medical Society Library.)

Medical—Friday, 10 a. m.

Surgical—Thursday, 9 a. m.

University of California Hospital, San Francisco

Medicine—Ward rounds, daily, 10 a. m. to 12 m.; general staff rounds, Wednesday, 10 a. m. to 12 m.; amphitheater clinics, Saturday, 10 a. m. to 11 a. m.; clinical pathological conference, Saturday, 11 a. m. to 12 m.; out-patient clinics, daily; examination of apparently healthy adults, Thursday, 10 a. m. to 4 p. m. Surgery—Operative, phone supervisor operating-room; ward rounds, Thursday, 10:30 a. m. to 12 m.; amphitheater clinics, Saturday, 9 a. m. to 10 a. m.; clinical pathological conference, Saturday, 11 a. m. to 12 m.; out-patient clinics, daily.

Pediatrics—Ward rounds, daily, 9 a. m. to 10 a. m.; general staff rounds, Friday, 9:30 a. m. to 11:30 a. m.; out-patient clinics, daily, mornings; asthma clinics, Monday, Wednesday and Friday afternoons; examination of apparently well babies, Wednesday, 2 p. m. to 4 p. m.

Obstetrics and Gynecology—Operative, phone supervisor operating-room; ward rounds, Monday, 9 a. m. to 10 a. m.; Friday, 9 a. m. to 10 a. m.

College of Medical Evangelists, Los Angeles (Clinics at Los Angeles General Hospital)

Surgery—Monday, 8:30 a. m. to 9:45 a. m.; Tuesday, 8:30 a. m. to 9:45 a. m.; Friday, 8:30 a. m. to 11:15 a. m.

Medicine—Monday, 8:30 a. m. to 11:15 a. m.; Tuesday, 8:30 a. m. to 9:45 a. m.; Wednesday, 8:30 a. m. to 9:45 a. m.; Thursday, 8:30 a. m. to 12:30 p. m. Conference—Friday, 8:30 a. m. to 9:45 a. m.

Pediatrics—Monday, 8:30 a. m. to 9:45 a. m.; Tuesday, 8:30 a. m. to 9:45 a. m.; Wednesday, 8:30 a. m. to 9:45 a. m.; Thursday, 8:30 a. m. to 11:15 a. m.

Obstetrics—Monday, 9:45 a. m. to 11:15 a. m.; Friday, 9:45 a. m. to 11:15 a. m.

Nervous and Mental—Tuesday, 8:30 a. m. to 11:15 a. m.

Tuberculosis—Friday, 9:45 a. m. to 11:15 a. m. (Clinics at White Memorial Hospital, Los Angeles)

Surgery:

Clinics Monday, 8 a. m. to 12 m.

Clinical lecture Monday, 11:30 a. m. to 12:30 p. m. Tonsillectomy Sunday, 8 a. m. to 12 m.

Tuesday, 8 a. m. to 12 m.

University of California, Los Angeles

The Los Angeles Medical Department of the Uni-

versity of California extends the courtesy of its clinics, which begin daily at 12 noon, for a period of three days. Physicians desiring such courtesy are given, on request, cards of admission by the superintendent of the dispensary.

Accredited Hospitals

The following accredited hospitals receive visiting physicians at operations, and furnish telephonic schedules of the day's work upon request:

Livermore—The Livermore Sanitarium.

Los Angeles—California Lutheran Hospital, Children's Hospital, Los Angeles County Hospital, St. Vincent's Hospital.

Oakland—Samuel Merritt Hospital.

San Diego—St. Joseph's Hospital.

San Francisco—Children's Hospital, French Hospital, Mary's Help Hospital, Mount Zion Hospital, St. Luke's Hospital, Southern Pacific General Hospital.

San Leandro—Alameda County Hospital.

MORE ABOUT THE FAMILY PHYSICIAN

In a consideration of the general practitioner it will be necessary to discuss the opportunities which he enjoys, and the problems and difficulties which beset him. In their work, not all general practitioners are resourceful and sure of themselves. This fault is due in some instances to inadequate early training, but in a majority of men it is due to laziness and failure to take advantage of the opportunities afforded all physicians. From the time of his graduation until he retires from work, the whole professional life of the physician affords opportunities to study morbid processes as evidenced by anatomic changes and altered function and so to manage and treat the patient that partial or complete restoration occurs—dependent, in part, on the nature of the malady. The physician who makes all possible use of his daily clinical opportunities learns something new and useful every remaining day of his professional life.

Membership in and active participation in the work of the county medical society is of great educational benefit to the physician. It affords personal contact with fellow-practitioners in the courteous discussion of medical subjects and professional problems, promotes mutual respect and good-will, and is a potent factor conducive to increased self-respect and self-reliance on the one hand, and to a decrease in the size of the hat, if imaginary megalomania makes one a nuisance to his fellows.

With due regard for the value and need of all the splendid ultrascientific laboratory and instrumental methods of physical and functional diagnosis in investigatory medical work, they are needed in the routine clinical care of not to exceed 20 per cent of all the patients of any urban or rural community. Unfortunately, many lay people have been made to believe and apparently a large number of physicians think that the routine application of the ultrascientific methods of diagnosis is necessary in the majority of cases. The fact is that the diagnosis can be made in fully 80 per cent of all cases by a resourceful general practitioner who will efficiently use his brain, special senses, hands and an always available simple and inexpensive laboratory and instrumental equipment.

A majority of practitioners do not make written records of their patients: these are absolutely essential to accuracy in diagnosis and efficiency in practice. To obtain an efficient history and make a record require time. Many practitioners have told me they could not afford the time to do this. My own experience justifies the statement that this is a mistake. Accurately written records, brief though they be, properly filed to be available for future reference, are time-savers of the future weeks, months, and years.

The conscientious practitioner will make a careful, general physical examination of practically all

patients who seek his services. An occasional patient with a slight ailment, and especially those with slight injuries or lesions requiring surgical treatment, are exceptions. But with many patients the present complaint is often an expression of an older morbid process which has been disregarded by the patient or overlooked by the physician. Daily practice in technic and judgment is the program which every physician must follow to become a skilled diagnostician. The practitioner can gain much by observing others at work in organized clinics or by taking post-graduate courses in diagnosis, when these are available; but the efficiency of the practitioner in diagnosis is mainly dependent on his own industry and determination to make the most of his own clinical opportunities.

There is a growing custom in urban practice for general practitioners to have the routine laboratory examinations, such as urinalysis, blood estimations and other simple tests made and the results interpreted for them at the numerous available commercial laboratories. In my opinion, this is a great fault in practice; it would be quite as rational for the practitioner to depend on available organized clinics for the physical examinations and diagnosis of patients.

But whether one is a practitioner in the city or in the country, the economic conditions peculiar to each can be greatly improved by one's own efforts. The fundamental principle which each practitioner must adopt to overcome his economic embarrassment is to improve himself professionally. To accomplish this, I believe he must steadily follow the methods of clinical practice and other self-educational opportunities which I have outlined. I sincerely believe that, if he will do this, he will attract to himself a large number of patients, will receive more adequate financial reward, and will find real enjoyment in his work.

Many years ago an observing philosopher said: "The pathway to the door of the qualified man, desirous of giving honest, efficient service to the public, is worn smooth by the passage of many feet."

I believe that the preservation of the general practitioner, as the most important factor in the field of practice, is dependent, chiefly on himself. He must keep abreast of the advance of modern medical knowledge and practice, chiefly by his own efforts. If he strives to improve and help himself he will be successful; will justify his importance in the medical field, and will attract the ill and injured to his door because of his professional individual superiority as compared with men in narrower fields of practice, alone or in public or private groups.

The American family home has been and must continue to be the very foundation of this nation. Bolshevistic socialism, anarchy, and public discord cannot exist in a nation of family homes. The integrity and perpetuation of this nation is dependent chiefly on the maintenance of family life; and the continuance of the family home demands the preservation of the family physician, the general practitioner.—Frank Billings, M. D., Journal A. M. A.

The future of human civilization depends primarily upon the rearing of its children. These children will require more and more education to fit into this gradually enlarging scheme, but above all they will need health education so that they can gain personal comfort, release from suffering, and a longer period of productive life after the necessary prolonged periods required for adequate mental training. It will take at least another generation before a majority of us in any land can even think biologically. We cannot hope to control many eugenic factors, so that our efforts must be largely directed to changing the environment of the human animal.—Ray Lyman Wilbur, M. D.

WHY DOCTORS BUY WORTHLESS AND FRAUDULENT SECURITIES

By SAMUEL O. RICE

(Educational Director, Investment Bankers Association of America.)

Physicians who number bondmen, investment bankers, among their patients frequently complain that bondmen squander their health.

"The heads of three bondhouses," my family doctor said to me the other day, "are patients of mine, they and several subordinate officers of other houses, and I'll be hanged if they aren't more careless with their health than is all the rest of my practice put together. They'll work like demons for months at a time and then try to make up for the loss of daily exercise and common-sense routine by trying to crowd a year's recreation into a few weeks. They'll eat, and drink, too, a lot of stuff that's bad enough at home, but is doubly damaging when they take frequent business trips, with irregular hours, heterogeneous food, and the unavoidable strain of an exacting business. They are the worst spend-thrifts of health that I know among intelligent men."

"At least they are not as bad as doctors," I replied to my friend's amazement. "When they need medical service you've got to admit they don't go to quacks for it. They go to the reputable profession and to recognized specialists, don't they?"

"What has that got to do with it?" the doctor asked. "Physicians can't avoid irregular hours, but they're not—"

"The argument is," I interrupted, "on the use of common sense, isn't it? You say that bondmen don't use common sense about health. But as lax as they are in that, they are not as lavish in squandering health as physicians are in squandering money in so-called investments. Bondmen at least exercise common sense enough to realize that it requires a doctor to exercise medical judgment for them. How many physicians realize that it requires a 'doctor' of investments to select investment securities dependably? Ever hear of an investment banker being swindled by a quack practitioner? How often are physicians swindled by quack investment schemes?"

"There are just two reasons why doctors, as a class, are notable for buying worthless securities. One of them is their failure to realize that, in seeking good, sound investments, you have to do exactly the same thing you do in seeking health—consult an honest, competent practitioner."

"What's the other reason why we buy worthless securities?" my friend asked with a smile. "Because doctors are not business men?"

"That's the reason usually given, but I don't believe there's anything to it. The second reason is too much optimism."

"There isn't one of you who doesn't believe that next year's practice is going to be a whole lot more remunerative than this year's. Your first years of practice, when you started with nothing and gradually built up your income, taught you that. It's firmly fixed, perhaps subconsciously, in every doctor's mind. It's a life thought-habit of the profession, besides being a somewhat common human trait."

"Well, if things are going to be better next year, I'll just take a few hundred dollars of the stock of this patent electrical device or in that new serum outfit, you argue. Thousands of little oil and mining companies have been organized in the last few years among little groups of friends in every town, city and hamlet in the United States, and have blown up after losing the money put into them. I'll wager that in every such little venture 90 per cent of them have had one or more physicians as stockholders. As a profession, you are so confoundedly optimistic you let your optimism run away with your better judgment, and you accumulate a lot of nondescript interests in a number of things

you know nothing about and that have little or no value when your widow tries to realize on them."

"Yes, I guess some of that is possibly true," my friend admitted.

"True, of course it's true. Six months ago I had a little ready money and I asked you to send me your bill. I telephoned you twice. I got that bill last week, six months after I had put my little ready money into some sound investments selected by an investment specialist and not by inexperienced friends or an easy-talking promoter. Now, when I'm shy of cash, you optimistically send me a bill. I'll bet you \$4 you are going to buy a new car. You are careless about collections, partly because it is in the code of your profession not to be mean and grasping. I honor you for that, but your eternal optimism is also a part cause. Oh, you say, I'll get more money next month; if not from Jones, from Smith. And you base your investments on the same kind of careless optimism."

"I'm serious in this, Roy. You wouldn't have a bit of sympathy for me if I disregarded the common sense that the medical profession has patiently drummed into the public for years, the fact that the public must consult reputable, competent medical advisors. You'd have a silent contempt for me if I let some quack or gaudy fake practice in my family, or if I answered a cure-all medical advertisement."

"The so-called intelligent public has learned its lesson in medicine, that of consulting reputable practitioners. It is just as important that the medical public learn the same lesson as applied to investing their money. You nor no other physician can judge an investment security dependably, if you continue attending to your legitimate vocation. Even if you had time to do it, very frequently you haven't the facilities to determine the worth of a security. Investment banking is such a highly specialized calling that I doubt if any man has the ability to perform the investment banker's work without adequate training in the work."

"Physicians should be the first persons in the world to recognize this fact, but, strange to say, many of them do not. As a consequence, they are notably heavy losers in bad investments. And the cure for this bad investment condition is the same as in a human pathological condition—consult the reputable specialist who is competent to treat the case."

LECTURE FOUNDATION IN PREVENTIVE DENTISTRY

The inaugural lectures under the Carnegie Grant will be given in Los Angeles on the evenings of January 3 and 4, at the College of Dentistry, University of Southern California, and will be open to the professions only. In San Francisco, the professional lecture will be given on January 7, at the College of Dentistry, University of California, at 3 p. m., and the public lecture in the Italian room, St. Francis Hotel, on the same day, at 8:15 p. m. The public lecture will be repeated in Wheeler Auditorium on the Berkeley campus, on Tuesday evening, December 8, at 8:15 p. m.

The title of the professional lecture will be "Progress and Outlook for the Prevention of Dental Disease." The title of the public lecture will be "Dentistry and Health."

This course of lectures will be delivered by Arthur D. Black, Dean of Northwestern University Dental School, Chicago, Ill. Black is widely known, internationally as well as nationally, and is a leader in this great movement in America.

Our civilization cannot survive materially unless it be redeemed spiritually. It can be saved only by becoming permeated with the spirit of Christ and being made free and happy by the practices which spring out of that spirit. Only thus can discontent be driven out and all the shadows lifted from the road ahead.—Woodrow Wilson.

MEDICAL ECONOMICS

Why not let our advertisers help you?

New Canyon Sanatorium Annex—This issue of the Journal contains a page advertisement for the new Canyon Sanatorium Annex for the treatment of tuberculosis, at a rate of \$15 a week for patients unable to pay the regular charges. Increasing facilities for the treatment of tuberculosis in sanatoriums at rates that can be afforded by people of ordinary incomes will do much in the campaign against this insidious disease. Doctor Ralph B. Scheier, medical director, states that the present unit is only a beginning and that others will be added as the demand warrants, until there is accommodation for 100 patients. Continuing in his discussion of this project, the medical director says:

"Cases of selected type only will be admitted to the annex. A rate of \$15 per week will be charged. This rate includes medical attention, nursing supervision, bed and board. In order to make possible a rate which is less than the cost of maintenance a plan has been instituted by which the deficit will be met by the profit which accrues from Canyon Sanatorium. In bringing this venture before you we feel that a big sociological problem is being solved, and trust that you will give this project the editorial comment which it deserves.

"This project has been made possible through the support of the medical profession. Seven years ago Canyon Sanatorium started with five beds. It might be interesting for you to know that our success has in a large measure been made possible by bringing Canyon Sanatorium to the attention of the medical profession by advertising the sanatorium in the California State Journal of Medicine."

Medical and Scientific Reference Books—We are pleased to call attention to an advertisement in this issue of the Journal showing the establishment in San Francisco of a firm interested exclusively in promoting the sale of medical and scientific literature. Large Eastern cities have for many years had numbers of stores of this kind. San Francisco has needed a movement of this kind for a long time, and it is a pleasure to see that Mr. Stacey has taken a step in the right direction.

The Radiodor—Attention of physicians and hospitals is called to the advertisement of the Radiodor now being carried in the Journal. This electric vaporizer was shown at the conference of the hospitals of California held in San Francisco recently and at the American Medical Association annual session, and is being used by many hospitals and physicians. The Journal would be glad to have comment on the use of this instrument from physicians and hospitals.

The More Practical Functional Tests of the Liver—Max Einhorn, New York (Journal A. M. A., Nov. 3, 1923), reviews the various tests proposed for estimating liver function such as the general activity of the liver, which can be demonstrated by the color reaction which is produced by the liver in the bile after the entrance of various substances into its circulation. The permeability of the liver can be studied by the method devised by Abel and Rowntree and later on improved by Aaron, Beck and Schneider, by injecting tetrachlorphenolphthalein. The faculty of the liver of utilizing the biliary pigment, when the latter in returning from the intestine by the portal system, has reached the former organ, is best ascertained by testing the urine for urobilinogen. The albumose-storing power of the liver is determined by Widal's test based on the well-known fact that after the ingestion of food there is usually an increase of leukocytes present in the blood. This test Einhorn says does not at present appear to us that it will prove of much assist-

ance. The storing faculty of the liver for sugars and fats is best investigated by the sugar tolerance tests and by the lipase content of the blood. The presence of galactose can be elicited by Nylander's test, or by the usual Fehling or Benedict test for sugar. The fat-storing ability of the liver may be tested by examining the blood for its lipase content. While all these functional tests give hints as to the workings of the liver or its failure to work, these alone will never enable one to make a diagnosis of any special disease of this organ.

The Blight of Standardization—In discussing this subject, President Eliot said: "A new blight is afflicting education and industries in the United States. . . . Its name is standardization. . . . It is obvious standardization has become a dangerous adversary of progress in both education and industry. The ideal in education is to develop the utmost possible variety of individual attainment and group attainment; just as the true goal of democracy is the free development of the utmost variety of capacity in the individual citizen. . . . The true educational goal is the utmost development of the individual's capacity or power, not in childhood and adolescence alone, but all through life. Fixed standards in labor, in study, in modes of family life or of community life, are downright enemies of progress for the body, mind, and soul of man."

DEATHS

Barber, David Cassat. Died at Blythe, December 2, 1923, age 61. Graduate of Miami Medical College, Cincinnati, 1886. Licensed in California, 1886. He was a member of the Los Angeles County Medical Association, the California Medical Association and a fellow of the American Medical Association.

Callanan, Joseph Ignatius. Died at San Francisco, November 20, 1923, age 34. Graduate of the Stanford University School of Medicine, San Francisco, 1916. He was a member of the San Francisco County Medical Society, the California Medical Association and a fellow of the American Medical Association.

Edwards, Samuel G. Died at Los Angeles, November 11, 1923, age 55. Graduate of the Medical College of Ohio, Cincinnati, 1893. Licensed in California, 1900. He was a member of the Los Angeles County Medical Association, the California Medical Association and a fellow of the American Medical Association.

Fehlen, August. Died at San Francisco, November 13, 1923, age 63. Graduate of Cooper Medical College, San Francisco, 1894. He was a member of the San Francisco County Medical Society, the California Medical Association and the American Medical Association.

Friedman, William Lloyd. Died at Oakland, December 1, 1923, age 51. Graduate of the Baltimore Medical College, 1897. Licensed in California, 1898. He was a member of the Alameda County Medical Society, the California Medical Association and a fellow of the American Medical Association.

Owens, Frederick Francis. Died at Ely, Nevada, November 23, 1923, age 51. Graduate of Columbia University College of Physicians and Surgeons, New York, 1896. Licensed in Nevada, 1901. He was a member of the Nevada State Medical Association and the American Medical Association.

Thomas, Clifton A. Died at Albany, Oregon, October 10, 1923. Graduate of the Kansas City Medical College, Missouri, 1905. He was formerly a member of the San Francisco County Medical Society, the California Medical Association and the American Medical Association.